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ABSTRACT

In 1976, with a grant from the National Institute of Mental Health, the Sex and Disability Unit began training disabled and nondisabled professionals and paraprofessionals to serve as sociosexual educator-counselors for physically disabled persons; this is the final report of that project. Training included lectures on the sexual aspects of specific medical conditions and disabilities, role-playing of counseling situations, practicum experience, and group sessions dealing with explicit sexual material. In their field placement, trainees were supervised in program development and in the provision of direct educational and counseling services to clients and inservice training to staff. Analyses of evaluation data indicate that trainees met or exceeded project objectives. Over 90% of the graduates found employment or attended college or graduate school subsequent to their training. Project staff and graduates are available as consultants to help establish similar training programs. (Author/CS)

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THE SEX AND DISABILITY TRAINING PROJECT

1976 - 1979

FINAL REPORT

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U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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Finally, and most importantly, we wish to thank the men and women who enrolled in the training and allowed us to learn together with them. Each contributed uniquely to a richer understanding of human sexuality.

ABSTRACT

In October 1976, with a grant from the Experimental and Special Training Branch, Division of Manpower and Training Programs, National Institute of Mental Health, the staff of the Sex and Disability Unit began training disabled and nondisabled professionals and paraprofessionals to fulfill the role of sociosexual educator-counselors for physically disabled persons, health care providers and rehabilitation and habilitation agencies.

The year-long training (1,000 hours/20 hours per week) included didactic lectures on the sexual aspects of specific medical conditions and physical disabilities, role-playing of counseling situations with videotape feedback, practicum experience in counseling and education relating to sexuality and disability, and small group sessions in which comfort with discussion of sexually explicit material was encouraged as one aspect of personal and professional growth. A significant number of the consultants presenting didactic information were professionals who were themselves physically disabled.

The practicum (field placement) experience was obtained at a wide variety of settings including residential long-term care facilities, non-residential independent living programs, college-based disabled students' programs, acute and extended-care hospitals, outpatient rehabilitation centers, vocational rehabilitation facilities, ambulatory care units, and family planning agencies. At these agencies, trainees were supervised in the provision of direct educational and counseling services to clients, inservice training of staff, and program development.

From 31 persons selected, a total of 28 persons (19 disabled and 9 nondisabled) completed the training over the three years of this grant. Analyses of evaluation data obtained from the trainees (pre, post training assessments of skills and knowledge), and from the field placement sites (ratings of trainee effectiveness), indicated that trainees met or exceeded project objectives. A further validation of this performance was seen in the fact that over 90% of the graduates became employed or attended further college or graduate school subsequent to their training.

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CHAPTER I

INTRODUCTION

Sexuality and Disability Services

The disabled man or woman who achieves a level of sexual functioning and self-esteem that is personally satisfying, will usually develop the self-confidence and assertiveness necessary to form meaningful relationships, to develop work ability, and to be otherwise productive.[1] Commonly, however, since most persons equate self-worth with adequate sexual function, those who feel discouraged about their sexuality often become disabled in other respects. Thus, for the physically disabled person, adequate sexuality is not a frill or a luxury to be attended to only after all other needs have been met; instead, it may be a central element of total rehabilitation.[2]

The U.S. Rehabilitation Act of 1973 mandated that more resources be concentrated on working with the severely physically disabled to enable them to live independently and to take their rightful place in society and the work world.

Relatively unacknowledged in the past, the inclusion of sexual health care is now seen by many as integral to these goals and to the development of comprehensive community and institutional services for the disabled.[3-8]

The need to address these issues has also been recognized by the World Health Organization (Division of Family Medicine), the American Medical Association, American Psychiatric Association, American Psychological Association, American Orthopsychiatric Association, American Academy of Family Practice, Rehabilitation International, Neuro-Musculo-Skeletal Group of the California Conference in Rehabilitation, and many other professional organizations.

Increasing interest in sexuality and disability has recently been indicated by the expanding number of books and articles,[9] the publication of a new professional journal,[10] films of a professional and commercial nature,[11,12] and international and national conferences devoted to this topic.[13,14]

All of the foregoing assert and promote the right of disabled persons to be considered by themselves and by others as sexual and social beings.

These are certainly positive developments, but much remains to be done in order to translate these attitudes and ideas from professional discourse into actual implementation. Sexuality education, counseling, and related services remain as yet unavailable for most persons who have had acute illnesses, for example, heart attacks, and surgical procedures such as mastectomy. Lack of these services also hinder the habilitation, rehabilitation and social integration of persons disabled by cerebral palsy, multiple sclerosis, spina bifida, spinal cord injuries and other medical conditions. Trieschmann,[15] in her comprehensive report on the status of research into the psychological, social and vocational aspects of spinal cord injury, cautioned that the research assessing the behavioral outcome of sexual health services for the disabled and rehabilitation staff has not yet been done. Reasearch is needed to determine who should be trained (and in what manner) to offer what kinds of services to what kinds of clients wishing which set of specific changes in their lives.

Our efforts must not stop with the simple recognition that persons with disabilities are sexual. Indeed, if left at that, other problems will supplant the old. For example, a study by Hanson and Franklin[16] found that rehabilitation staff may in some cases overestimate the importance that spinal cord injured patients initially place on their sexual functioning. This could be as much if not more of a problem than if staff underestimate such concerns. Destructive iatrogenic effects can occur whenever staff or other authorities set inappropriately high or low expectations of sexual functioning or impart and impose their own particular values concerning sexual attitudes and behaviors.[17,18]

In what may be a useful analogy, LoPiccolo and Heiman[18] questioned "How many women patients developed feelings of sexual inferiority as a result of a therapeutic (or cultural) view of women as second rate substitutes for men?" One might also suggest that attempting to match an image of "superwoman" in contemporary American society could also be problematical. Similarly, ignorance of the processes whereby cultural values dictate that only physically "normal" persons have the right to sexual relations will perpetuate the definition of disabled persons as asexual beings. The project described herein had as a main objective the training and subsequent increase in visibility of disabled persons who were comfortable with their own sexuality and competent to discuss sexual issues with professionals and their clients.

Who Should Deliver These Services?

Eisenberg and Falconer[19] recommended that agencies not rely on outside consultants in sexuality, who would be available only at restricted times, but instead train, via inservice, their own staff who were comfortable with their own sexuality and interested in providing such services. They suggested that traditional disciplinary boundaries should pose no restrictions on selection of staff to be trained. Paraprofessionals and peer counseling have been effective in providing sexuality education and counseling to college students[20-22] and to the physically disabled.[23] The latter study, using data from the first year of the Sex and Disability Training Project, reported the positive outcome of having disabled (peer) and nondisabled professionals and paraprofessionals act both as consultants to staff and provide direct educational counseling services to clients. Such a dual role for paraprofessionals has also been suggested by D'Augelli.[24] Benefits of this approach include the fact that a combination of information provided by and contact with the disabled results in increased positive attitudes toward the disabled by able-bodied staff.[23,25] Additionally, successful and adaptive role models are provided for disabled clients. Research to evaluate disabled versus non disabled counselors and educators in particular service functions is now seen as a critical need.[1,15]

What Type of Training will be Most Effective for What Category of Service Provider?

Presumably, most professional staff in habilitation, rehabilitation, and other counseling agencies have had training in basic therapeutic counseling skills. There now exists considerable evidence that trained paraprofessionals can be as effective or more so than professionals in providing mental health services to a variety of clientele.[24] Models for training basic and advanced helping skills have been developed and validated,[26,27] as well as specific skill models pertinent to sexuality and disability.[23] The above training programs rely to a great extent on the proven ability and effectiveness of modeling, role-playing, and feedback processes.[28]

What Kind of Service will be Most Effective when Delivered by Whom to What Category of Client ?

In contrast to the medical or treatment model, the educational model described extensively by Guerney and his colleagues[29] results in an enhancement-oriented rather than a remedial or problem-oriented conceptual system.

In such an approach, "individuals and small groups are taught life skills by trainers who are more closely enacting a teacher than a therapist role."[24]

Techniques which have been found important and effective in assisting persons with disabilities to more fully integrate sexuality into their lives include values clarification,[30,31] social skills,[1,15,32-34] and assertiveness training,[35-37] in addition to the basic provision of factual sexual information.

How Can the Effectiveness of These Services be Measured?

The evaluation strategies commonly utilized to determine the multiple factors involved in assessing the effectiveness or adequacy of service delivery rely principally on the self-reports of the clients/patients, reports of the care provider, and on statistical indices such as the frequency of requests for care. Effectiveness of specific interventions, e.g., social skills or assertiveness training, typically involves an assessment of the client /patient behavior before and after the intervention. Numerous instruments have been developed to assess the attitudes and behavior in the areas mentioned above: values clarification,[30,31] social skills,[36] and assertiveness training.[35,37]

In the final analysis, the effectiveness of any comprehensive habilitation or rehabilitation intervention is going to be determined by the frequency with which the clients/patients become integrated into the larger society at a "successful" level; the definition of success will vary with the maximum potential of the clients/patients and the social and cultural milieu in which they are living. With respect to sociosexual functioning, this would typically involve subjective estimates of satisfaction arising from activities performed in this domain.

This report details the efforts of one group to address many of the above mentioned issues important for the delivery of appropriate sexual health services for persons with physical disabilities.

History, Description and Objectives of the Human Sexuality Program

The program was formally constituted in 1972 as an organized activity of the School of Medicine devoted to the study of human sexuality. One of the first comprehensive Human Sexuality Programs in medical schools in the country, it offers related educational, counseling, and professional training to a full range of health professionals. In 1976, it became a program of the Department of Psychiatry at about the time of the death of the founder and director of the program, Herbert Vandervoort, M.D. On June 1, 1978 a new permanent director was appointed, Evalyn Gendel, M.D. She has had an extensive background in providing sexuality training to health professionals in relation to disabled and nondisabled children and adults.

The Human Sexuality Program is comprised of the Sex and Disability Unit, the Counseling Clinic, the Academic and Continuing Education Service, and the Research and Evaluation Unit. The major goal of the Human Sexuality Program is to promote sexual health by:

1) advancing basic knowledge of human sexuality; and
2) developing and evaluating methods of promoting sexual health.

To reach this goal the program utilizes an interdisciplinary approach in the following activities:

1) conducting basic and applied research;
2) developing approaches for treating sexual problems;
3) providing clinical services and training in sex counseling and therapy;
4) devising educational and training methods;
5) providing academic and continuing professional education and consultation to institutions and agencies.

Research and evaluation efforts have concentrated on the validation of educational courses, counseling training activities and therapeutic interventions used in counseling of clients with sexual problems. A major clinical outcome study of a predominantly low-income sample of counseling clients is currently being conducted. Basic research is occurring in the areas of sex role behaviors and sexual expression and on the relationship of early somatosensory experiences to subsequent sexual behavior.

The Human Sexuality Program is housed in two locations in San Francisco, California. The Administrative Offices, Education Department, and Counseling Unit are adjacent to the campus of the University of California, San Francisco.

A description of other training activities of the Human Sexuality Program is presented in Appendix A.

The Sex and Disability Unit, at 814 Mission Street, San Francisco, houses the six staff members involved in the Unit's counseling, training, educational and administrative activities. The Unit's offices are part of the Multi-Service Center for the Disabled, a consortium of agencies providing a full range of services related to disability. These agencies provide trainees of the project with the expertise needed in the areas of employment advocacy, independent living skills, and physical accessibility. Permanent equipment obtained by the Sex and Disability Unit includes portable videotape equipment used to provide immediate feedback to participants in training sessions and a wheelchair-accessible van used to transport disabled trainees.

In July 1976, the Sex and Disability Unit received a three-year grant from the Office of Education, Bureau of Education for the Handicapped, HEW, to augment the training of special education teachers in new approaches to family life education for disabled students. This project, Family Life Education Training for Teachers and Parents of the Physically Disabled, was based on a short-term training model which involved a sequence of three weekend workshops and practicum experience in developing and implementing sociosexual curricula in the classroom setting. Evaluation activities on this grant centered on the effectiveness of the weekend workshops. While the course was evaluated using pre/post questionnaires, the data obtained from an assessment of the quality of the curricula developed and the frequency with which they were instituted in the respective school systems showed strong support for the validity of the project. At the end of the final year, 325 teachers had received the training thus providing the potential for bringing improved instruction in Family Life Education to 8,000 students.

The Sex and Disability Training Project

Also in July 1976, the National Institute of Mental Health, (Experimental and Special Training Branch, Division of Manpower and Training Programs) awarded a three-year grant to the Sex and Disability Unit to train 30 educator-counselors in sexuality for the disabled. This grant, the Sex and Disability Training Project, benefited from didactic presentations and consultations from staff involved in the Family Life Education Project; furthermore, this latter project provided workshops each year at which Sex and Disability Training Project Trainees could practice and be evaluated on their sex education and small group facilitation skills.

A detailed presentation of the rationale and objectives of the Sex and Disability Training Project is considered in the following section of this report.

CHAPTER II

RATIONALE AND OBJECTIVES

Rationale

The goal of the Sex and Disability Training Project was to help physically disabled persons achieve more satisfactory sexual functioning and relationships, thus positively affecting their integration into the mainstream of society. Included in this overall goal was the promotion of the self-esteem and mental health of disabled people.

Over the several years prior to this training project, the Human Sexuality Program had developed a series of short courses which were presented to groups of health/helping professionals, and also to disabled persons, their families, and their intimates. These courses varied in length and format. Participants' evaluations as well as comments and letters, clearly supported the value of the courses. In fact, the disability programs, or portions of programs, consistently received the highest participant ratings. Professionals reported that such courses helped them to reach a new understanding of the unique needs and feelings of the disabled, to respond with greater empathy and comfort to their disabled patients, and often to achieve a clearer awareness of their own sexuality. Those participants who were themselves disabled reported that the courses helped them to regain their self-esteem as sexual and adequate human beings and that their relationships with family members and others were enriched.

Of central importance to this program was the recognition that a great deal of ignorance surrounds the sexuality of persons with disabilities. To counter commonly-held assumptions (promoted in popular media) that "only the young, beautiful, and able-bodied are truly sexual" and similar myths that accord those who are disabled an "asexual" status, this project selected and trained persons, a majority of whom were disabled, to be educator-counselors in the area of sexuality and disability. This project was especially interested in assessing the impact of disabled educator-counselors who were comfortable and competent to discuss sexual issues with health care staff and disabled consumers. Since many

health care staff primarily have contact with disabled "patients" or "clients", it was hoped that they would benefit by interacting on a professional "peer" level with the trainees. The disabled clients would also see the educator-counselor as a peer, and as someone who is active, productive, competent and free from the "patient" role or status. Finally, both staff and patients/clients would be able to view trainees as role models of disabled persons comfortable in discussing sexual issues and competent in helping others address these personal issues.

This non-degree program trained sex and disability educator-counselors to help physically disabled persons achieve more satisfactory sexual functioning and personal relationships. These trainees, of whom 70% were disabled and 30% were nondisabled individuals, received five months didactic training in general sexuality counseling, sex and disability education, and general counseling skills. During the next seven months, trainees received further didactic instruction and supervision of their field placement experience in one of a variety of rehabilitation settings. This preparation allowed them to deal with disabled persons, family members of the disabled and health care delivery personnel in the area of sexuality and disability. Wider vistas of employment for these sex and disability educator-counselors were developed during the course of the project.

Objectives

The objectives of the Sex and Disability Training Project were as follows:

1. To train 30 persons as sociosexual educator-counselors for the disabled.
2. That 70% of trainees would themselves have physical disabilities.
3. To assess trainee skills and knowledge in sociosexual education and counseling.
4. To assess trainee productivity during the training year.
5. To assess project graduates' occupational and educational status post-training.
6. To develop, evaluate, and disseminate training and other materials related to sexuality and disability.
7. To develop selection criteria for this type of training program.
8. To develop an effective/replicable/economical system with which to provide sex information and counseling on a peer level for disabled persons and health care providers.

CHAPTER II

PROCEDURES

Theoretical Orientation of the Training

Effective sex educators possess specialized skills. We agree with Dickman's[38] outline of the personal qualities of a good sex educator. These include:

1) A healthy attitude about one's own sexuality;
2) an empathy and sensitivity to others' values, attitudes, and feelings;
3) the ability to maintain a professional relationship with one's students while communicating in an open and trusting manner;
4) the ability to create a climate in which students are able to express their own feelings and opinions; and
5) an understanding of and commitment to protecting the student's confidentiality.

We also espouse an *educational model* of counseling[29] in contrast to a medical or treatment model. This results in an enhancement-oriented conceptual system. In such an approach, "individuals and small groups are taught life skills by trainers who are most closely enacting a teacher than a therapist role."[24]

Much experience has been gained in the training of paraprofessionals from community mental health centers to provide direct counseling services.[39,40] In addition to training and skill building in counselor qualities of warmth, respect and genuineness,[41,42] trainees in the current project were specifically trained in techniques corresponding to Annon's[43] levels of intervention for sex counseling; the *PLISSIT* model of *P*ermission, *L*imited *I*nformation, *S*pecific *S*uggestions, and *I*ntensive *T*herapy. When clients were assessed as most likely to benefit from intensive therapy, trainees were expected to refer clients or to request more intensive supervision and consultation. Although some of the trainees had master's level training in counseling prior to beginning this program, staff impressed upon all trainees, clients, and agency staff, that trainees were best seen as resource persons with information to share and an ability to listen and give useful feedback. They were not represented as psychotherapists. As with Annon,[43] it is our opinion that the majority of sexual concerns that exist, and in this case which pertain to the physically disabled, can be successfully dealt with at the *PLISS* levels without the need for intensive therapy.

We were aware, of course, that not every prospective educator-counselor would possess the qualities necessary to become an effective sex educator, even

after intensive training. Instead, our goal was to facilitate our students' awareness of the levels of intervention at which they felt most comfortable in dealing with various aspects of sex education and counseling, to strengthen existing counseling skills most relevant to sociosexual rehabilitation, and to provide knowledge about when and how to make referrals for a variety of services, including intensive therapy.

It was expected that graduates would function as members of health care teams, adding their skills as health educators and counselors to the skills of other disciplines. They also ultimately served as consumer advocates, since most were themselves experienced consumers of habilitation and rehabilitation services.

Recruitment and Selection of Trainees

Recruitment Process

Recruitment was accomplished through advertisements in key professional and consumer journals, through announcements at professional meetings, and through letters to key personnel in rehabilitation and sexuality programs throughout the country. The State of California became the primary source of trainees because of the financial burden placed upon participants and lack of travel and relocation funds for out-of-state applicants. Even so, of the total of 31 trainees involved in the program, two moved to San Francisco for the training from New York, one from Boston, and one from Portland; three commuted from the Santa Cruz, California area; four were from Sacramento; two were from Northern California; one moved and one commuted from Los Angeles; and 16 were from the greater San Francisco Bay Area.

Selection Process

A Trainee Selection Committee was appointed by the Director of the Human Sexuality Program and included one professional staff member from the Human Sexuality Program, one professional staff member from the Sex and Disability Unit, and two disabled persons representing community agencies.

The Trainee Selection Committee reviewed written applications and two letters of recommendation from each interested applicant. Each applicant was asked to delineate in writing both personal qualifications in relation to the training as well as how he/she intended to use the taining to further career goals. After this screening, suitable applicants were then contacted for a

two hour interview(in Year I, one hour each with two staff persons; in Years II and III, one hour each with a staff person and with a project graduate).

Selection of trainees followed a model used successfully by the general counseling training component of the Human Sexuality Program. Preference was given to trainees with previous counseling (or analogous) experience. Inherent abilities or traits valuable in counseling such as warmth, genuineness and respect, could substitute for extensive prior counseling experience. Therefore, some trainees with high levels of such abilities and traits were accepted without their having had as much prior counseling experience as other applicants. It must be remembered that this project provided training in *both* counseling and education techniques and that it was expected that some graduates would eventually work principally as health educators.

Finally, the Trainee Selection Committee attempted to select a group with approximately equal numbers of females and males, and in which approximately 70% were disabled.

Selection Criteria

Minimum standards for selection included:

1. 21 years old (over 18 years old, if able to demonstrate unusual maturity).
2. Educational background which included a high school diploma or its equivalent; a minimum of 1-2 years satisfactory college work was preferred.
3. Physical health satisfactory to allow active participation in the 30 hour per week project.

Trainee personality qualities sought included:

1. Commitment to the goals and objectives of the project.
2. Ability to communicate effectively, especially in relation to disabled people.
3. Respect for rights of individuals.
4. Interest in employment in the field of sex and disability following graduation.

Training Activities

Weekend Workshops

At the beginning of each year-long training class, the trainees participated in two intensive workshops (totaling over 75 hours during three weekends) presented by the Human Sexuality Program to health professionals:

1. "Health Aspects of Human Sexuality". This first weekend course was an educational process depending heavily upon the use of film, didactic presentations, and small group interaction. It provided substantive sexual information that is necessary to understand the full range of sexual behaviors and also emphasized special sexual aspects of patient care and rehabilitation. Topics included: historical graphic erotica, the human sexual response cycle, sexual patterns, male sexuality, female sexuality, hetero-and homosexuality, principles in sex counseling, sex therapy approaches, medical aspects of sexuality, sex and disability and ethical considerations of sexuality.

2. "Introduction to Principles of Sex Counseling". This course took place over two consecutive weekends. The couples co-counseling method provided the basic structure, as well as a context for exploring fundamental aspects of functional and dysfunctional sexual behavior. Other treatment approaches were also presented. The emphasis was upon broad principles that are adaptable for the needs of a variety of individuals or couples. Its focus, however, was primarily upon working with nondisabled populations. Topics included: sexual anatomy and physiology, the sexological examination, social scripting of sexuality, an overview of sex therapy approaches, and demonstration and practice in basic communication skills, taking a sex history, and the prescription and use of various "homework" exercises.

Didactic Phase

Concurrent with the above workshops and continuing during the first five months of each year-long program, the trainees met 16 hours per week (two days, 10:00 a.m.-6:00 p.m.) together with the three project staff. Each trainee was required to spend an additional four hours per week minimum in reading (see Appendix B), keeping a personal journal, and developing a research paper. Emphasis was placed upon didactic instruction and experiential learning in basic counseling theory and techniques (as well as those utilized in sex education and counseling) and presentation of information regarding human sexuality, and physical disabilities and medical conditions. Consultants were utilized who were particularly knowledgeable in these areas (see Appendix C). It was felt most important by the staff that a significant number of them should have acquired personal experience with a disability. They greatly enriched our understanding of the scope and implications of this area of study. Trainees evaluated all consultants with rating scales of topic importance and relevance and quality of presentation, as well as in staff/trainee discussions.

Training components and their approximate times were:

Didactic presentations by staff and consultants (4 hours per week)

Large group processing of sex and disability issues, resource sharing, feedback, administrative issues, etc. (7 hours per week)

Small-group experience of five trainees and one staff member for personal growth and supervision	(3 hours per week)
Role playing of counseling and education issues	(3 hours per week)
Co-counseling of actual clients with staff	(1 hour per week)
Individual research on topics of interest	(2 hours per week)
Personal journals	(½ hour per week)
Required reading	(3½ hours per week)
Speaking on panels at various workshops (varying with ability and interest of each trainee).	

Practicum Phase

During the last seven months, trainees and staff met one day per week to continue the above activiites and to supervise field placement experiences, at which each trainee spent an additional day and one-half per week. Field placements utilized are listed in Appendix D. In these field placements, trainees were expected to provide consultation and inservice presentations to staff and to provide short-term counseling to clients based on an educational rather than medical or psychotherapeutic model. All such activities were supervised by the agency supervisor (on-site) and by the staff of the Sex and Disability Training Project.

Curriculum

(A more thorough description of the curriculum will be found in Appendix E)

For most people, sexual contact at the genital level is only a component of the larger arena of interpersonal contact. Trainees were encouraged to view sexual contact as serving a variety of human needs: those for intimacy, sensuality, nurturance, joy, and self-esteem as well as reproduction. Teaching focused on the ways in which men and women express their sex roles and the ways in which people communicate with and relate to one another.

The curriculum was geared toward presenting sexuality within its social contexts. For example, special attention was given to couple and family dynamics. Trainees were taught to evaluate the disabled individual as part of a family system or other interpersonal network. Basic family therapy techniques useful in diagnosis and intervention were also presented. Trainees also could participate in didactic sessions and case conferences of the Human Sexuality Program's general sex counseling training program which enrolls qualified psychotherapists.

Trainees were given overviews of other resources available to disabled individuals for dealing with special problems that might impede sociosexual rehabilitation. Such resources included agencies providing family planning, treatment for veneral disease, suicide prevention counseling, crisis intervention, and interpersonal communications training.

Course Content

The development of course content included identifying texts and journal articles relevant to sexuality and disability and that were appropriate for paraprofessional training. The majority of the most informative sources in this area of study were articles in a variety of medical and psychological journals. Specific concerns regarding sexuality and disability often presented by clients were identified and scripted by the staff for role playing by trainees. Required reading was evaluated through both staff/trainee discussion and rating scales.

In addition to the material on human sexuality presented at the weekend workshops (described above), topics included:

1) Sex and Disability - Emphasis was upon various disabilities and medical conditions as they relate to sexuality, including: neurophysiology and neuro-endocrinology of sexual response cycle, reproductive and contraceptive aspects of specific disabilities, and sex and body image;

   disabilities and medical conditions such as cerebral palsy, dwarfism, mental retardation, multiple sclerosis, muscular dystrophy, post-polio, spina bifida and spinal cord injury; arthritis, cancer, cardiovascular problems, ostomy surgery, pulmonary disease, renal conditions and uro-genital problems.

2) General Education and Counseling Skills - Emphasis was upon practical aspects of educational counseling, including: role playing and structured practice pertaining to the following areas of social skills development;

   body language, communication of one's wants and needs, dealing with acceptance and rejection, effective expression of anger and perserverance.
   Principles and practice of communication skills included: active listening, assertion training, dynamics of one-to-one and group processes, problem-solving techniques and role playing.

Small Groups

Small groups of approximately five trainees and one staff person met weekly throughout the training for personal growth, support, supervision and experience in group process. These groups provided valuable opportunities to discuss sexual and other personal concerns in a supportive atmosphere, to experience both the role of educator-counselor and of the client in personal problem solving, to give to and receive feedback on counseling skills from other trainees and staff, to receive supervision for field placement activities, and to critique the training program itself.

Client Contact

An educational rather than "therapeutic" model was emphasized in dealing with clients at the Sex and Disability Clinic. A part of our sociocultural deprivation has been the adoption of a narrow definition of sexuality which consists primarily of penile-vaginal intercourse. Validating the view that sexuality encompasses our feelings, thoughts, and *various* behaviors (including perhaps holding hands with someone you love) and recognizing that sexuality is not limited to the young, "beautiful", deodorized, and able-bodied, does much to alleviate the "problem" for many disabled and nondisabled persons alike.

We believe that the above messages often may be heard more readily by one disabled person when it is given by another.

This is not surprising when we recall that Masters and Johnson[44] felt that it was important in the sex therapy of heterosexual couples to have therapists of each sex who could "interpret" the feelings and experience of the same-sex client (the dual sex therapy team). Similarly, disabled paraprofessionals can serve as role models of sexually competent and comfortable persons for both clients and health care providers, and are often best able to articulate the experience of disabled clients.

The counseling approach of the Sex and Disability Training Project thus encompassed a short-term educational effort; permission for disabled persons to consider themselves, and to be considered by others, as sexual beings; help in improving social skills and a positive body image; and support in their search for satisying interpersonal relationships. Each trainee saw a minimum of two clients with a staff person as co-counselor. Sessions were tape-recorded and trainees were given feedback by staff directly and by the use of client ratings at three-month follow-up.

A preliminary analysis of follow-up data from 35 of the 90 clients seen at this clinic indicates a positive response to these brief counseling sessions by over 75% of these clients.

Practicum Field Placements

During the Practicum Phase trainees continued to meet as a group one day per week, and were in field placements for an additional 8-12 hours per week. Among the agencies used were rehabilitation hospitals, independent living centers, state university disabled students' programs, and a residential center for disabled persons. One trainee moved to Ann Arbor, Michigan, and did her field placement at a nonresidential center for independent living. As with more local field placements, this proved to be a very successful experience for the agency, the trainee, and staff. Depending on available agency resource personnel, trainees were either supervised directly by agency supervisors and by the project supervisor, or by the latter alone. Tape recordings of client sessions, direct client and supervisor feedback, and staff feedback from trainee inservice presentations for agency staff were all utilized. Evaluation of field placement experience was by trainee final report and agency supervisor ratings (see Appendices F and G).

Trainee Research Papers

Each trainee was required to research a particular topic of interest in the area of sexuality and disability, and to submit it at the conclusion of the training year. Typical reports incorporated a literature review, a personal perspective on an issue in disability or sexuality, and data obtained from interviews with persons having a particular disability. Topic areas chosen included:

Sexuality and arthritis
Sexuality and mastectomy
Sexuality and birth control
Sexuality and assistive devices
Sexuality and multiple sclerosis
Sexuality groups for disabled women
Sexuality and bowel and bladder care
Sexuality and the young adult with an ostomy
Sexuality issues for women who are quadriplegic
Sexuality and the role of the physical therapist

Trainee Journals

Each trainee was encouraged to keep a personal journal during the training. It was the option of the trainee whether or not to submit this to staff.

Personal Presentations

Each trainee gave a minimum of two personal presentations during educational programs and workshops which were sponsored by outside agencies, the Sex and Disability Training Project, or by the Human Sexuality Program. The 31 project trainees gave a total of 350 presentations during the three years of the project (1976-1979). These included talks on issues in sex and disability and personal perspectives on sexuality for clients and for inservice training at various agencies. Evaluation of these teaching activities was accomplished by staff, trainee, and client rating scales and by immediate feedback.

Behavioral Contracts

A behavioral contract "Memorandum of Understanding" was developed which detailed the specific responsibilities of trainees and staff, and included information about the growth group experience in conformance with the American Psychological Association's Guidelines for Psychologists Conducting Growth Groups (1973). A similar contract was developed for field placement agencies (see Appendices H and I).

Evaluation

Evaluations of each trainee's performance included self-ratings and ratings by other trainees, clients, agency supervisor, and project staff in counseling qualities such as empathy, respect and genuineness; critiques of workshop presentations; a research paper; a final report of the field placement experience and final evaluation of the training (see Appendix J). More immediate though less formal feedback in trainee small groups was encouraged throughout the training.

The "Agency Supervisor Evaluation Questionnaire" (see Appendix G) was developed so that the field placement agency supervisor could rate the trainee at the completion of the placement. It was seen as a major validational tool to contrast with project staff and trainee ratings. It included 30 multiple choice Likert-type items (rated "1" = most favorable, "6" = least favorable), plus open-end items. The Carkhuff Scales[41] of empathy, respect, and genuineness

were modified and included. Each of these scales consisted of five descriptive paragraphs as examples of increasing levels of therapist functioning. Agency supervisors were asked to choose one of the levels (1--5) which corresponded most to their judgment of the trainee's counseling; they could also choose a level of functioning between the scale levels.

Numerous studies have related these scales to a variety of therapeutic outcomes, and they possess face (content) validity by corresponding to several dimensions of interpersonal processes.[42]

Agency supervisors were mailed the evaluation materials and were requested to complete and return them. These supervisors had professional backgrounds in counseling, medicine, nursing, occupational and physical therapy, or social work. All questionnaires were completed and returned to the project within six weeks of the completion of the field placement experience.

Recommendations of Trainees

Each trainee who successfully completed the program was given a letter of recommendation (see Appendix K) which stated either:

1) the trainee was competent to do sociosexual education-counseling under the supervision of qualified professionals;

2) the trainee was competent to do co-counseling only with a qualified professional; or

3) the trainee needed more basic counseling skills and personal growth experiences.

Graduates also were given a certificate of completion (see Appendix L).

CHAPTER IV

RESULTS

Trainee Profiles

For the Year I training group, 38 applications were processed, 25 applicants were interviewed, and 11 applicants were accepted. Within the first two weeks, one person terminated in order to accept a position as coordinator of an independent living center in Sacramento. Another left the training after two months because of difficulty in commuting weekly from Bakersfield to San Francisco (over 300 miles). Of the nine who remained, all completed the training.

Insert Tables 1-3 about here

For the Year II training group, 48 applications were processed, 36 applicants were interviewed, and 12 were accepted. One trainee terminated after six months because of a non-disability related illness and transportation difficulty. The remaining 11 trainees all completed the training.

For the Year III training group, 53 applications were processed, 30 applicants were interviewed and 10 were accepted. Two trainees terminated after six and seven months, respectively, because of non-disability related illness and transportation difficulties. The remaining eight trainees all completed the training.

Not counting the two trainees from Group I who left the training within two months as noted above, 31 trainees took part in this project. Of these, 22 were disabled (14 used wheelchairs), and 9 were nondisabled. The disabilities included cerebral palsy, dystonia, multiple sclerosis, myotonia, post-polio, rheumatoid arthritis, spina bifida, and spinal cord injury.

Project Objectives

Project objectives were evaluated as follows:

Objective 1) To train 30 persons as sociosexual educator-counselors for the disabled.

Result (Indicator) 31 persons began the training and continued for at least six months.

29 (93.5%) completed at least nine months of training.

28 (90.4%) completed the full year of training.

Objective 2) To include at least 70% of trainees who were themselves physically disabled.

Result 22 of the 31 persons (71%) selected for the training were physically disabled.

Objective 3) To assess trainee skills and knowledge in sociosexual counseling and education.

Result Trainees were evaluated on repeated measures (4, 8 and 12 months) of counseling qualities such as empathy, respect and genuineness (Carkhuff Scales) by project staff, trainee peers, and self-ratings; and were assessed by the "Agency Supervisor Evaluation Questionnaire" for their field placement experience. These different sources of trainee evaluation data were highly inter-correlated, thereby enhancing the stability and validity of the inferences based on these data.

Overall change scores indicated significant pre/post improvement on self, peer, and supervisor ratings of the counseling dimensions of empathy, respect and genuineness. For the combined trainee group, all nine change scores showed significant improvement; eight were significant beyond the .01 level. For the disabled trainees, seven of the nine change scores were significant, while all nine change scores were significant for the nondisabled group.

Insert Tables 4-6 about here

Ratings by staff of empathy, respect and genuineness showed significant differences at the time of the pre-measure between experienced and nonexperienced trainees. The post-measures revealed a convergence of mean rating scores on

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Insert Table 7 about here

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the dimensions of respect and genuineness, with the nonexperienced trainees showing a significant increase (see Figure 1).

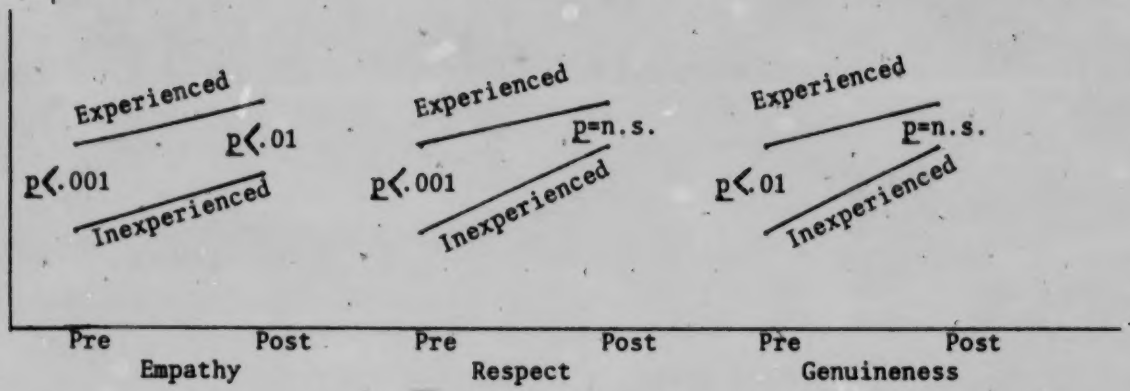

FIGURE 1

PRE/POST STAFF RATINGS FOR EXPERIENCED VERSUS INEXPERIENCED TRAINEES

Follow-up measures of empathy, respect and genuineness as rated by peers, project staff and field placement supervisors provided nine comparisons between disabled and nondisabled trainees. Of these only two project staff ratings

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Insert Table 8 about here
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and one self-rating achieved statistical significance. Given that only three out of a possible 21 comparisons achieved significance indicates a high degree of similarity between mean levels of these dimensions by the various raters. In virtually all dimensions and sources of ratings, the degree of variability was higher for the disabled group, thus reflecting a greater degree of heterogeneity in that sub-sample. It is especially important to note that the mean level of ratings by field placement supervisors attest to the high level of criterion-oriented validity achieved by the training project.

The field placement questionnaire was judged by 27 of 28 agency supervisors to be adequate with which to convey the supervision process and to evaluate the trainee. Analyses of these ratings yielded validating results. In each of the three major areas of concern - trainee personal growth, competency, and

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Insert Table 9 about here
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client/staff outcome - the impressions of the supervisors were favorable.

With respect to their personal qualities, the trainees were seen as being comfortable with their own sexuality, and with discusssing sexual topics with clients and with staff. They were also seen as being knowledgeable about disability issues. They were judged to be fairly knowledgeable about basic counseling techniques and to be somewhat-to-fairly experienced in overall counseling skills, an evaluation consistent with their paraprofessional status. Also of importance, trainees were seen as having accurately represented their level of skills and abilities to others. In respect to the Carkhuff scales, trainees rated high in empathy, respect and genuineness, dimensions of considerable importance for peer counselors.

Supervisors observed significant positive change in clients, although there was considerable between-trainee variation on this dimension. Supervisors indicated they were satisfied with the trainees' overall counseling and educational activities.

In regard to influence upon field placement agency staff, agency supervisors indicated that a fair amount of positive change occurred as a result of the trainees' activities. In sum, the supervisors indicated that their agencies benefitted from the trainees' activities.

Responses to the open-ended questions, in addition to supporting the foregoing analyses, indicated that staff in the placement agencies became more aware of the importance of sexual issues and more comfortable in addressing them. They learned more about the interrelatedness of body image, self-esteem and sexuality; and became more sensitive to the way in which unnecessary architectural barriers increase the alienation and diminishment felt by disabled persons. Two illustrative comments follow:

> The staff in general became more comfortable in discussing sexual issues. Patients needed someone to talk to about their sexuality and sexual functioning on a consistent basis and (the trainee) provided this. We were extremely satisfied with the field placement experience.
>
> It is the first time in the history of our institution that human sexuality has been openly recognized as part of the totality of rehabilitation. (The trainee) has helped create an atmosphere for recognition of sexuality as a basic need.

Objective 4) To assess trainee productivity during the training year.

Result In accordance with the memo of understanding (Appendix H), trainees submitted research reports, reports of field placement experiences and personal journals. They were also evaluated on the number of educational presentations made to professional and consumer groups, number of clients seen at their field placement agency and at the Sex and Disability Clinic.

Based upon the number of talks ($\bar{x}$ = 12.2, sd = 10.12) given by trainees and estimated audience-size, together with numbers of clients seen at field placements and at the Sex and Disability Clinic, it can be documented that over 20,000 people received direct services by trainees. The three core project staff members gave an additional 130 lectures and workshops to an estimated 8,000 clients and health professionals. It is also estimated that over 50,000 individuals were acquainted with major issues in sexuality and disability presented by staff and trainees on ten local radio and television programs.

Follow-up evaluation of clients seen at the Sex and Disability Clinic is continuing and will be written up in future reports. Preliminary data analyses indicated that the majority of clients benefitted from and were satisfied with their brief counseling experience.

Objective 5) To assess project graduates' occupational and educational status post-training.

Result Follow-up reports of project graduates indicated that 20 of the total of 28 graduates (71%) obtained paid employment relevant to the sexual concerns of the disabled. Six graduates enrolled in master's degree programs in counseling and psychology. Two were not reachable for follow-up.

Insert Table 10 about here

Prior to the training, 2 trainees were employed *and* in school, 8 were employed, 6 were in school, and 15 were neither employed nor in school. At follow-up (6-12 months post-training), 10 graduates were employed *and* in school, 11 were employed only, 6 were in school only, and 4 were neither employed nor in school.

Therefore there has been a net increase of 8 trainees employed and in school, 3 trainees employed only and a net decrease of 11 trainees that were neither employed nor in school.

Objective 6) To disseminate information and to develop training and other materials related to sexuality and disability.

Result During the three years of this grant, 20 project-related articles were published or accepted for publication in a variety of professional journals and books. A workbook and curriculum

guide in sex and disability training is being developed. (A copy will be submitted upon completion). Staff and trainees have given lectures and workshops to a wide variety of professional and consumer groups, including the American Association of Sex Educators, Counselors and Therapists; American Psychological Association; Society for the Scientific Study of Sex; and the World Congress of Sexology.

In addition, project staff planned and organized the first national symposium on sexuality and disability, attended by 380 participants in May 18-20, 1979, in San Francisco. A second symposium is scheduled for May 16-18, 1980, in Berkeley, California.

Objective 7) To develop selection criteria for this type of program.

Result As a result of multivariate analyses using several demographic variables, there appeared to be no significant variation accounted for by the demographic characteristics. Hence, while the subjects were initially heterogeneous with respect to levels of counseling ability, experience and educational level, these variables did not account for any variance in the outcome measures.

Objective 8) To develop an effective/replicable/economical system with which to provide sex information and counseling on a peer level for disabled persons and health care providers.

Result Examination of the previous seven objectives and results indicates that this project has developed a highly effective and economical training model. Trainees rated the various components of the training year quite highly, and felt that the experience was of

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Insert Table 11 about here

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considerable benefit to them both personally and professionally. In order to encourage the widest range of application and replicability, a training workbook is being completed. However, the present half-time full year training model was seen as costly in terms of trainee time and commitment and staff involvement. An alternative model was developed to minimize these two major sources of cost without sacrificing the inherent validity of the effort. This model, Short-Term Intensive Training in Sex and Disability, is currently undergoing testing and evaluation (see description of this project Chapter VII; Recommendations).

CHAPTER V

DISCUSSION

Group Process

Each group was remarkably diverse in respect to trainees' age range, degree and type of physical limitation, previous couseling experience, sexual orientation, and values. A forum developed in which participants could accept, reject, ignore, confront and/or learn from one another's life goals, sexual values, disability, counseling styles, political awareness, ability to deal with anger, professional or consumer identification, and basic humanness. Several of the Year I trainees had been politically active in the struggle for enforcing the rights of the disabled. To some extent, this led to an initial distrust and testing of professional staff and consultants. It was important for nondisabled trainees and staff to confront their own motivations for working with the disabled. Assertiveness training was incorporated to help both the less assertive and the aggressive learn more appropriate and effective interpersonal skills. To respond to these differences, instruction was individually tracked. It will also be important for replicative efforts to tailor-make the instruction to fit individual trainees.

Staff impressions were that by the end of the training, most if not all of the trainees had been able to overcome their stereotypes of the "professional", the "cripple", the "middle-class" or "lower class" person; and had gained knowledge about their own vulnerabilities and defenses.

In a very real sense, many of these persons functioned in their field placements and in later jobs as "liaisons" between professional health care providers and consumers. The year's experience helped give those who closely identified with consumers a positive experience with health professionals and professional standards; those who came from a professional background learned about the effects of misdirected professional services on disabled people. All groups increased their empathy and understanding of those they may have previously rejected as being "in the wrong".

Massage Workshop

A highlight of the training experience was a day spent at a massage school called Getting-In-Touch in the Santa Cruz Mountains. It is a California state-approved vocational school that has offered Body Awareness and Wholistic Massage workshops since 1972. Its facilities include a hot tub, sauna, pool and lodge.

Trainees were given the option of attending the one-day workshop. Twenty-six trainees and all staff participated in the experience over the three years. Initially there were several logistical matters which needed attention. The facilities at Getting-In-Touch were not fully accessible to persons in wheelchairs. Ramps and bathroom alterations were made. There was also concern about how people would get in and out of the hot tub, and on and off massage tables. Some people needed assistance with dressing and using the bathroom. Arrangements were made for additional staff from G.I.T. to assist with lifting. Trainees preferred not to include their personal attendants in the workshop; instead, trainees and staff volunteered to assist each other as needed.

Trainees were given the opportunity to discuss their feelings for several weeks prior to the massage workshop in order to decide whether or not they wished to participate. After the first year, trainees who had already attended the workshop volunteered to talk with those who were thinking of going. Many persons openly admitted their reservations about nudity, discomfort about body image, and general fears and anxieties in anticipation of the experience. After attending the workshop, however, their reactions were overwhelmingly positive. Many, in fact, described the experience as the highlight of the training. One trainee summarized the experience eloquently as follows:

> An interesting thought hit me the other day, while sitting in an outdoor hot tub with 11 friends. My thought was that everyone looked the same -- peaceful, relaxed, a slight grin on most faces. A true feeling of closeness seemed to be the general mood shared by all of us.
>
> Sameness is not usually one of my needs, but sometime it would be nice not to have to hassle the unconscious stigmatizing and stereotyping that often happens to people who appear different.
>
> What brought all this up is that about a dozen of my friends, both able-bodied and not so able-bodied, went to a place called Getting-In-Touch. We went there because we care about ourselves and each other, and this fine place provides an environment that allowed us to see ourselves and each other in a new way.

Six of us were in wheelchairs, and it's safe to say that our bodies don't quite live up to TV, Madison Avenue, Vogue or Playboy concepts of "the body beautiful". And I think that is true, also, of the others who didn't have to be carried, manhandled (womanhandled?) and lowered into the tub.

I don't use "plumbing" (a catheter and leg bag), so I don't know how some of my friends felt to be that exposed and perhaps that vulnerable in such a social setting.

There were big bodies, little bodies, straight bodies, not so straight bodies. There were enough new things exposed to each of us that I'm sure the old locker room concern of penis size or breast size was the least of anyone's worry. In fact, once we made the initial commitment of getting into the tub, the only concern I felt was that the day would end much too soon.

Sitting in the hot tub relaxed more than our bodies. The self-induced anxieties and apprehensions we had been building up over the preceding days relaxed, too. Later, as we went into the large and comfortable lodge-type room, I guess some anxiety returned, briefly, because we were about to embark on a "massage" sharing, if we chose to.

The word "massage" may convey different images to different people. What we all shared, within the confines of our physical ability, was a moment in time where it was OK to be caring, to be intimate without being sexual, to be sensuous without being threatened. We weren't there to give or receive a therapeutic rubdown or Paris fingertip special. We were there to experience our own joy in touching and being touched by another human being. When one thinks of the word "touch" usually the hands come to mind. But consider one woman who can't lift her hands far from her lap. Her touch was done with her chin, lips and cheeks.

Many of us with limited or no feeling on our hands are very conscious of the way we touch someone else -- and even more conscious of what we think the other person is feeling. How neat it was to find that a back or leg doesn't have the same perceptions as a brain.

This was a day, a brief instant, where we could give ourselves permission to just be -- to put our body image away and just appreciate what it could give and receive.

--Terry Brickley

Resources

Staff and Consultants

(See Appendix M)

Advisory Committees

1. Trainee Selection Committee. This committee met during each selection process. Its function was to insure that a heterogenous group of qualified applicants be selected.

2. Ad Hoc Handicapped Access Committee, University of California, San Francisco. This committee was established by order of the Chancellor following the submission of a report by project trainees and staff describing architectural improvements that would make the University campus more accessible to the disabled. Two trainees from this project were selected as committee members.

3. Employment Advisory Committees. In March, 1978, the staff convened a meeting of 10 persons involved in sex and disability education in New York City to explore possibilities for the employment of project graduates on the East Coast. As a direct result of this meeting, one project graduate was hired as a sex educator by United Cerebral Palsy Association of Queens, New York and the Northeast Coalition on Sexuality and Disability was formed. Ongoing correspondence with numerous professionals nationwide working in related areas and others interested in the project further promoted employment for graduates. Finally, all field placement sites were viewed as potential employers of project graduates.

Field Placement Agencies

Other important resources for this project included the 23 agencies (See Appendix D) that provided field placement experience for trainees during the practicum phase (last seven months) of training. Each trainee spent a minimum of ten hours per week at one agency, though several trainees sought experience at more than one agency. The following are descriptions of representative field placement agencies:

1. Alpha Place Apartments, San Jose, California. This non-profit organization offers attendant care and supportive services to 26 severly disabled adults living in an apartment complex. Resident ages range from 19 - 55 with a mean age of 26 years. Persons served include those with spinal cord injury, cerebral palsy, multiple sclerosis, muscular dystrophy, brain damage, post-polio, and epilepsy. The trainee was involved in individual, group, and couples counseling and education, as well as staff education.

2. Center for Independent Living, Berkeley, California. The first agency of its kind, C.I.L. is a service organization administered by and for disabled people. Services include attendant-reader referral, advocacy and financial counseling, wheelchair repair, mobility training for the blind, housing assistance, transportation, crisis counseling, a computer training project, and a training program for rehabilitation professionals.

Trainees were involved in group, couples, and individual couseling and education with both clients and staff.

3. Eden West Rehabilitation Hospital, Hayward, California. The population of 99 in-patients is distributed as follows: 20% geriatric chronic, 18% adults with cerebral palsy or multiple sclerosis, 22% adults with spinal cord injuries and other traumatic injuries hospitalized for short term rehabilitation, 25% adults with psychiatric problems, and 14% long term patients with spinal cord injuries and other traumatic disabilities.

A trainee was involved in staff education and consultation, individual and group patient counseling, and family counseling of patients and their families.

4. Mt. Diablo Rehabilitation Center, Pleasant Hill, California. This center specializes in out-patient diagnosis and treatment in the areas of audiology, education, medical psychology, physical therapy, and occupational therapy. It also sponsors a sheltered workshop for physically disabled adults. Their staff sees approximately 500 adults each month including those with spinal cord injury, stroke, cerebral palsy, multiple sclerosis, muscular dystrophy and amputation.

A day activities program was instituted in January, 1976, offering counseling and educational programs as well as recreational activities. The trainee was involved in group and individual counseling and education within this project as well as staff education.

5. Santa Clara Valley Medical Center, San Jose, California. This 600 bed facility is one of ten regional spinal cord injury centers, nationally. It offers medical services in spinal cord injury and general rehabilitation. The patient population has an average age range of 20-24 years.

5. (cont.) The trainee was involved in individual, group, couples, and family counseling and education, staff education and work with the rehabilitation team. The trainees also attended the ongoing rehabilitation didactics offered to the Center Staff.

Community and Agency Support

Support for this project on behalf of community agencies and individuals was evidenced by the following:

1) Twenty-three agencies served as field placement sites and provided on-site supervision of trainees.

2) During the three years of the project, staff and trainees responded to requests by agencies and individuals for information on sexuality and disability by giving lectures and workshops to a total of over 20,000 persons. Staff and trainees also appeared on several local television and radio programs. Among the national and regional organizations for which presentations were made, were:

American Association of Sex Educators, Counselors and Therapists
American Psychological Association
American Urological Association
Society for the Scientific Study of Sex
World Congress of Sexology

3) Many consultants committed their time to provide didactic presentations to trainees for minimal or no fees.

4) Approximately 90 clients were referred and seen for counseling at the Sex and Disability Clinic; the majority of these referrals were initiated by area health care providers and educators.

5) The Chancellor of the University of California, San Francisco, established an Ad Hoc Handicapped Access Committee to help remove architectural barriers on campus as the result of a request by project trainees and staff.

Resistance

It would prudently be expected that individual and institutional resistance would be encountered when the two emotionally laden topics of sexuality and physical disability are combined. Overall, project staff were gratified with the positive community support outlined above. Two areas in which resistance was encountered, however, are described as follows:

1. It is remarkable that none of the sex education and counseling provided by trainees were considered inappropriate or controversial by field placement staff, project staff, or clients. The only occasion in which a trainee was requested to terminate field placement activities resulted from the following: the trainee facilitated a weekly group meeting of residents of a long term convalescent hospital to discuss sex education and social skills. After several initial sessions, the group requested information on independent living skills. The administration denied the request by the trainee to allow for such a discussion, and insisted that a hospital staff member be a nonparticipant observer at future group meetings. The trainee refused to comply, since the confidentiality of the group would be violated and the group contract invalidated by allowing such an observer. The trainee was supported in this decision by project staff. The decision to have the trainee terminate field placement activities at this agency was mutually agreed upon by the trainee, field placement agency, and project supervisor.

2. Two trainees with graduate degrees in counseling and physical therapy, respectively, had their field placement experience at the Cancer Research Institute, UCSF. Although supported and encouraged by the CRI Director, it was initially difficult to get CRI staff to refer patients to them for sex education and counseling. The trainees managed their frustration quite well by developing and implementing a formal needs assessment approved by the Human Subjects Research Committee of UCSF to study the sexual concerns of cancer patients. This resulted in two published articles and a book chapter.[45-47] As a result of their work, a subsequent trainee was given more staff support in this field placement. The experience with these patients and staff was atypical of that from other field placements, yet yielded substantial useful information about how to provide sexual education and counseling for patients facing life-threatening illness.

Other Difficulties

1. The need for truly accessible training and field placement sites cannot be overemphasized (see following section).

2. The availability of a wheelchair-accessible van in the project's second year alleviated many transportation problems.

3. Initially, much staff time and effort was needed to contact and educate potential field placement sites as to the goals of the project. As previously stated, however, they were very responsive to these efforts.

4. The full year half-time commitment by trainees made it very difficult for otherwise well-qualified persons to participate. Another training model is now being explored (see Recommendations).

5. Initially, there was mutual professional versus paraprofessional suspicion among trainees. As staff encouraged open communication about these concerns and as trainees and staff confronted and were confronted on these issues, a very positive resolution occurred in the great majority of instances.

6. It should be noted that rehabilitation agencies and personnel in the San Francisco Bay Area were for the most part acquainted with the peer counselor concept (although not in the area of sexuality) because of the success of the advocacy of staff at the Center for Independent Living in Berkeley, California. This agency was founded and staffed primarily by disabled professional and paraprofessionals. Other geographical regions may initially present more difficult problems of acceptance for peer counselors. However, our judgement is that there will be increasing support for this "self-help" concept nationally and that initial resistance can be overcome.

Accessible Space Needs

In May 1976, project staff began actively looking for appropriate training space that would be truly accessible to people in wheelchairs and others who were physically disabled. This proved to be a frustrating but ultimately rewarding task. While the space search continued, the project utilized the following accommodations during the training of Group I:

1. Administrative Offices: Two offices were made available to project staff by the Department of Psychiatry, UCSF, at the U.S. Public Health Service Hospital in San Francisco. These offices were inaccessible, and staff were unable to meet there with disabled persons in wheelchairs. Administrative functions were otherwise unhampered in this space.

2. Training Rooms: UCSF made available a classroom for use by the project. The room's immediate environment was sterile, hard, and cold. At times, construction and vehicular noise was a hindrance. Bathrooms were available but were not completely accessible. On occasion, the Chancellor's Conference Room was available for use by the Project.

3. Client Rooms: Some ambulatory disabled clients were initially seen in the Sex Counseling Clinic of the Human Sexuality Program (Suite 300, 350 Parnassus Avenue, UCSF). Disadvantages were primarily the lack of any accessible bathrooms in the building and a "back door" entrance for persons in wheelchairs. The project staff and trainees decided to make a priority the seeking of more suitable space for client services. An agreement was reached whereby offices in the School of Nursing, UCSF, were made available in the evenings for this purpose. These proved more adequate.

Thus, for the first year of operation, project staff and trainees by necessity used four primary location (USPHS Hospital; Old Clinics Building, UCSF; School of Nursing,UCSF; and the Human Sexuality Program Offices, UCSF). Driving and parking time between the USPHS Hospital and the UCSF campus was approximately 15-20 minutes. More striking was the amount of time and effort expended by disabled trainees in moving between the various UCSF locations. Parking facilities for the disabled were few and inadequate.

In December 1976, project trainees formally requested assistance from the Director of the Human Sexuality Program in increasing the accessibility of buildings, parking, and streets at UCSF. This request was sent to the Chancellor who responded by establishing and appointing an Ad Hoc Handicapped Access Committee, which included two trainees and a staff person from the project. The work of this committee made visible gains toward campus accessibility and awareness.

The project continued to search for space from which all training and administrative activities could be conducted. In June 1977, these efforts were rewarded as the project joined in a cooperative effort to develop the Multi-Service Center for the Disabled on the Second Floor of a building located at

814 Mission Street, in San Francisco. Other agencies in this consortium include the United Cerebral Palsy Association of San Francisco, San Francisco Chapter of the California Association of the Physically Handicapped, the San Francisco Independent Living Project, and the Employment Project for the Physically Disabled.

Having these various projects housed together contributed to the comfort, efficiency, and productivity of the project. Specifically, the space was renovated for ease of wheelchair access; clients seen by all the different service organizations were referred when appropriate; nearly all training and administrative functions were combined in one location; the project benefited from increased visibility and credibility in the disabled community and among other service organizations.

Trainee Research Projects

Under supervision of project staff, three trainees wrote research protocols that were approved by the Committee on Human Research, University of California Medical School. They were: "Arthritis and Sexuality Needs Assessment" and "Cancer and Sexuality Needs Assessment - Relationship, Intimacy and Sexuality Questionnaire".

Two additional research projects initiated by trainees included a study of the sexual attitudes of young persons (18-30 years old) with ostomies and a needs assessment of the extent to which physical therapists are trained to deal with the sexual concerns of patients and their self-perceived competence to do so. Data have been collected from over 50 and over 100 subjects in these respective studies.

Two articles,[45,46] one book chapter[47] and contributions to two other chapters[48,49] have resulted from the above activities, which were supported largely by this grant.

Sex and Disability Clinic

In the clinic established by the project in November 1976, staff and trainee co-counselors saw a total of 90 clients (including fourteen couples) during the three years. The majority were seen for a maximum of two sessions, indicating the educational, permission-giving, and problem-solving approach of the project.

In addition, over 60 clients were referred elsewhere or were counseled by telephone contact only. Disabilities represented included primarily spinal cord injury and cerebral palsy (40%), with 25 other distinct disabilities or medical conditions comprising the remaining 60% of the clients. An attempt was made to collect a minimum administrative fee of $10. for these services, but the fee was often waived due to the large number of low-income clients. Evaluation of counseling outcome is being assessed using counselor outcome ratings and a modification of the Post-Counseling Questionnaire, NIMH.

Implications

It remains as yet no easy task to assess clinical skill levels in counseling, both personality and behavioral dimensions are important. It should be acknowledged that although there has been much research support for the Carkhuff scales as used in this study and referenced earlier, other researchers have seen them as less useful.[50]

As measured by the multiple outcomes of this study, however, including the high percentage of project graduates who are now actively providing sexuality and disability services in employed positions, we feel that this training model is a significant methodological development. The project has stimulated new lines of research, has contributed substantially to the knowledge base of this new field, and has provided facts and information ready for application.

Dissemination of Future Publications

A number of training materials and data-based articles will be forthcoming to add to the 20 project-related publications already completed. These will include a workbook/training manual/curriculum guide, and articles utilizing client data from the Sex and Disability Clinic. All materials will be forwarded upon completion to NIMH.

CHAPTER VI

SUMMARY

The 13 females and 9 males who were physically disabled comprised 71% of the total of 31 persons who began the training; the nondisabled trainees included 8 females and 1 male. Disabling conditions represented included arthritis, cerebral palsy, multiple sclerosis, myotonia, post-polio, spina bifida and spinal cord injury. Fourteen of the trainees used wheelchairs. In respect to previous training in counseling, 16 (52%) of the trainees had no experience prior to this project, 13 (42%) had some experience (up to two years), and 2 (6%) had more than two years of experience. Of the disabled trainees, 9 (41%) had had at least some prior counseling experience in contrast to 6 (67%) of the nondisabled trainees.

A total of 28 of the original 31 trainees (90%) successfully completed the year-long program. Analyses of the evaluation data obtained (pre-, post-training assessments of skills and knowledge and ratings of trainee effectiveness in field placement sites) indicated that trainees met or exceeded project objectives. Self, peer and staff ratings of trainees revealed significant pre- to post-training increases in levels of empathy, respect and genuineness. In examining post-training ratings of empathy, respect and genuineness, significant tests of mean differences on dimensions of sex and of disabled/nondisabled yielded no significant effects. The agreement between three staff raters on measures of education and counseling effectiveness of trainees was R = .789, indicating a high level of agreement.

Trainees of the project conducted over 350 workshops or lectures during the three years of the grant. In addition to clients served at field placement agencies, an additional 90 clients were seen for counseling at the Sex and Disability Clinic. In this instance, staff members acted as co-counselors with trainees. Several trainee research projects generated important needs assessment data in the areas of sexuality and arthritis, cancer, and ostomy, and in determining the role of physical therapists in responding to the sexual concerns of patients. A validation of this performance was demonstrated by the fact that over 90% of the project graduates were employed or attending undergraduate or graduate programs after the training. Thus, the utility and effectiveness of using peer educator-counselors has been demonstrated for the delivery of a variety of services related to sexuality and disability in both habilitation and rehabilitation settings.

CHAPTER VII

RECOMMENDATIONS

Dissemination of Information

A substantial amount of dissemination occurred thoughout the three years of this project. Over 20 publications in professional journals and books reported information obtained from this project. Over 450 talks were presented, including those given at national professional conferences. One project graduate wrote and produced a film on sexuality and disability that won a second place award at the 1979 International Rehabilitation Film Festival in New York City. Over 380 people attended the first national symposium on sexuality and disability that was organized by project staff.

The final report covering the entire project will initially be sent to professionals active in the field of sexuality, disability, and rehabilitation. A workbook and curriculum guide is also being developed. In addition, papers summarizing the project are to be presented at future professional meetings including the World Congress of Sexology (Mexico City; December, 1979) and the Second National Symposium in Sexuality and Disability (Berkeley, California; May, 1980). Project staff and graduates are available to consult with other organizations to help establish similar training programs.

Future Training Plans: Short-Term Intensive Training in Sex and Disability

As a result of the experience gained in this project, a subsequent grant was developed and funded for 1979-1982, Short-Term Intensive Training in Sex and Disability. In order to allow greater participation by persons currently employed and/or in other undergraduate or graduate programs, this project consists of a two-week summer intensive training followed by three weekends for training and supervison during the remaining year. Two persons (at least one of whom will be disabled) will represent each of 15 agencies per training year. These will be selected from 9 targeted regions in the Western United States over the 3 years of the project. Cost effectiveness of this training will be considerably increased, since three times as many persons will be trained under the new project in contrast

to that of the Sex and Disability Training project (90 versus 30) with approximately equal project funding. Also, rather than being primarily restricted to trainees from the San Francisco Bay Area, this project's format will allow for the training of persons from throughout the Western United States.

The goal of this new project is for trainees to function within their home communities, as sex educator-counselors for physically disabled persons and for various members of the health care team both during and following the training period. At the conclusion of the training, a resource and referral network will exist in each area to continue these services. Graduates will be awarded a certificate of completion.

It is expected that within the time framework of the project, which is thirty-six (36) months, a working cadre of ninety (90) persons affiliated with forty-five (45) agencies will be providing the following types of services within their communities:

1. individual, small group, and large group education of agency clientele
2. staff in-service training
3. referral information on a variety of services for the disabled
4. consultatio. to agencies and individuals to facilitate the provision of comprehensive sociosexual services within the community.

The use of disabled educator-counselors allows for heightened utilization of the consumer's perspective and articulation of life experience. Necessary insights are provided, as well as exemplary role models integral to effective education and counseling. Secondly, based on experience in the Sex and Disability Training Project, persons will gain access to employment and training opportunities through practicum experience in their sponsoring agency.

The short-term training format will allow employed personnel to obtain instruction without extended leave from the work place. It also allows for all participants to remain within their community throughout the training process. This format will facilitate the development of sex and disability educational services within the local community and throughout the region.

TABLE 1

PARTICIPANT DESCRIPTION COMBINED, 1976 - 1979

	TOTAL	%
TOTAL	31	(100%)
FEMALES	21	(67.7%)
MALES	10	(32.3%)
DISABLED	22	(71.0%)
NONDISABLED	9	(29.0%)
WHEELCHAIR USER	14	(45.2%)
MEAN AGE	29.9 (SD= 7.4)	
AGE RANGE	22 - 56	
MARITAL STATUS		
SINGLE	16	(51.6%)
LIVING WITH	1	(3.2%)
MARRIED	3	(9.7%)
DIVORCED/SEPARATED	11	(35.5%)
PREVIOUS COUNSELING EXPERIENCE		
NONE	16	(51.6%)
LESS THAN 2 YEARS	13	(41.9%)
MORE THAN 2 YEARS	2	(6.5%)
HIGHEST DEGREE		
LESS THAN B.A.	9	(29.0%)
B.A.	17	(54.8%)
M.A.	5	(16.1%)
IN SCHOOL AT START OF TRAINING	7	(22.6%)
EMPLOYED AT START OF TRAINING	10	(32.3%)

TABLE 2

PARTICIPANT DESCRIPTION, GROUPS I - III, 1976-1979

	GROUP I 1976-77	GROUP II 1977-1978	GROUP III 1978-1979
TOTAL	9	12	10
FEMALES	5	8	8
MALES	4	4	2
DISABLED	7	7	8
NONDISABLED	2	5	2
WHEELCHAIR USER	6	4	4
MEAN AGE	28.0(SD=11.87)	30.6(SD= 8.99)	28.5(SD= 5.60)
AGE RANGE	24-44	22-56	22-40
MARITAL STATUS			
SINGLE	7	5	4
LIVING WITH	0	0	1
MARRIED	0	1	2
DIVORCED/SEPARATED	2	6	3
PREVIOUS COUNSELING EXPERIENCE			
NONE	4	7	5
LESS THAN 2 YEARS	4	4	5
MORE THAN 2 YEARS	1	1	0
HIGHEST DEGREE			
LESS THAN B.A.	1	4	4
B.A.	6	6	5
M.A.	2	2	1
IN SCHOOL AT START OF TRAINING	2	4	1
EMPLOYED AT START OF TRAINING	0	4	6

TABLE 3

PARTICIPANT DESCRIPTION, DISABLED VERSUS NONDISABLED

	DISABLED	NONDISABLED
TOTAL	22	9
FEMALES	13	8
MALES	9	1
WHEELCHAIR USER	14	0
MEAN AGE	31.00 (SD=7.99)	28.64 (SD=8.92)
AGE RANGE	22 - 56	22 - 33
MARITAL STATUS		
SINGLE	12	4
LIVING WITH	0	1
MARRIED	2	1
DIVORCED/SEPARATED	8	3
PREVIOUS COUNSELING EXPERIENCE		
NONE	13	3
LESS THAN 2 YEARS	7	6
MORE THAN 2 YEARS	2	0
HIGHEST DEGREE		
LESS THAN B.A.	7	2
B.A.	12	5
M.A.	3	2
IN SCHOOL AT START OF TRAINING	4	3
EMPLOYED AT START OF TRAINING	6	4

TABLE 4

PRE/POST TRAINING, SELF, PEER AND STAFF RATINGS OF EMPATHY, RESPECT AND GENUINENESS FOR ALL TRAINEES

	PRE		POST		
	MEAN	SD	MEAN	SD	STUDENT'S 't'
EMPATHY-SELF RATING	3.88	0.62	4.25	0.52	4.05 ***
RESPECT-SELF RATING	4.10	0.75	4.50	0.57	2.91 **
GENUINENESS-SELF RATING	4.08	0.52	4.39	0.54	3.68 ***
EMPATHY-PEER RATING	3.58	0.53	3.80	0.53	3.03 **
RESPECT-PEER RATING	3.86	0.47	4.21	0.45	4.60 ***
GENUINENESS-PEER RATING	3.83	0.50	4.08	0.48	3.04 **
EMPATHY-STAFF RATING	3.09	0.63	3.51	0.64	3.57 ***
RESPECT-STAFF RATING	3.16	0.53	3.69	0.65	4.20 ***
GENUINENESS-STAFF RATING	3.32	0.70	3.67	0.61	2.23 *

Note. - N = 28. Higher mean scores represent greater empathy, respect, and genuineness.

* $p < .05$

** $p < .01$

*** $p < .001$

TABLE 5

PRE/POST TRAINING, SELF, PEER AND STAFF RATINGS
OF EMPATHY, RESPECT AND GENUINENESS FOR DISABLED TRAINEES

	PRE		POST		
	MEAN	SD	MEAN	SD	STUDENT'S 't'
EMPATHY-SELF RATING	3.91	0.64	4.15	0.52	2.43 *
RESPECT-SELF RATING	3.91	0.78	4.35	0.61	2.15 *
GENUINENESS-SELF RATING	4.00	0.59	4.35	0.61	2.95 **
EMPATHY-PEER RATING	3.51	0.48	3.70	0.56	1.95
RESPECT-PEER RATING	3.77	0.45	4.13	0.50	3.56 **
GENUINENESS-PEER RATING	3.76	0.49	3.99	0.51	2.08 *
EMPATHY-STAFF RATING	2.97	0.61	3.35	0.69	2.30 *
RESPECT-STAFF RATING	3.05	0.51	3.55	0.70	2.80 *
GENUINENESS-STAFF RATING	3.23	0.71	3.55	0.70	1.49

Note. - N = 19. Higher mean scores represent greater empathy, respect and genuineness.

* $p < .05$
** $p \leq .01$
*** $p < .001$

TABLE 6

PRE/POST TRAINING, SELF, PEER AND STAFF RATINGS
OF EMPATHY, RESPECT AND GENUINENESS FOR NONDISABLED TRAINEES

	PRE		POST		
	MEAN	SD	MEAN	SD	STUDENT'S 't'
EMPATHY-SELF RATING	3.83	0.61	4.44	0.46	3.77 **
RESPECT-SELF RATING	4.44	0.58	4.78	0.36	2.83 *
GENUINENESS-SELF RATING	4.22	0.36	4.44	0.39	2.53 *
EMPATHY-PEER RATING	3.74	0.62	4.01	0.41	3.14 *
RESPECT-PEER RATING	4.04	0.48	4.38	0.29	2.98 *
GENUINENESS-PEER RATING	3.97	0.52	4.28	0.34	2.48 *
EMPATHY-STAFF RATING	3.34	0.63	3.86	0.32	4.23 **
RESPECT-STAFF RATING	3.39	0.52	3.98	0.43	4.70 **
GENUINENESS-STAFF RATING	3.52	0.66	3.92	0.23	2.30 *

Note. - N = 9. Higher mean scores represent greater empathy, respect, and genuineness.

* $p < .05$
** $p < .01$
*** $p < .001$

TABLE 7

PRE/POST TRAINING, STAFF RATINGS OF
EMPATHY, RESPECT AND GENUINENESS
FOR INEXPERIENCED AND EXPERIENCED TRAINEES

	NO PREVIOUS COUNSELING		LESS THAN 2 YRS COUNSELING		STUDENT'S 't'
	MEAN	S D	MEAN	S D	
Pre Training Empathy	2.65	0.65	3.47	0.52	3.77***
Post Training Empathy	3.17	0.69	3.78	0.41	2.73**
Pre Training Respect	2.84	0.55	3.45	0.43	3.34***
Post Training Respect	3.41	0.76	3.90	0.46	2.01
Pre Training Genuineness	2.96	0.77	3.64	0.60	2.68**
Post Training Genuineness	3.40	0.74	3.85	0.30	2.05

Note. - N = 16 in pre ratings and 13 in post ratings for trainees with no previous counseling experience.

N = 13 for trainees with less than 2 years of counseling experience. Higher mean scores indicate greater empathy, respect and genuineness.

* $p < .05$
** $p < .01$
*** $p < .001$

TABLE 8

PRE/POST
PEER, STAFF, AND SUPERVISOR RATINGS OF EMPATHY, WARMTH, AND GENUINENESS
FOR DISABLED VERSUS NONDISABLED TRAINEES

	DISABLED N= 22(pre) N= 17(post)		NONDISABLED N= 9 (pre) N= 9 (post)		STUDENT'S
	MEAN	S D	MEAN	S D	't'
Pre Training Empathy - Peer	3.45	0.51	3.74	0.62	1.26
Post Training Empathy - Peer	3.69	0.56	4.01	0.41	1.69
Pre Training Respect - Peer	3.72	0.45	4.04	0.48	1.76
Post Training Respect - Peer	4.13	0.50	4.38	0.29	1.64
Pre Training Genuineness - Peer	3.70	0.49	3.97	0.51	1.35
Post Training Genuineness - Peer	3.99	0.51	4.28	0.33	1.78
Pre Training Empathy - Staff	2.85	0.71	3.34	0.62	1.93
Post Training Empathy - Staff	3.35	0.69	3.86	0.32	2.63*
Pre Training Respect - Staff	2.96	0.57	3.39	0.52	2.02
Post Training Respect - Staff	3.54	0.70	3.98	0.43	2.01
Pre Training Genuineness - Staff	3.09	0.82	3.52	0.66	1.54
Post Training Genuineness - Staff	3.55	0.70	3.92	0.23	2.07 *
Post Training Empathy, Field Placement Supervisor	3.90	0.91	3.71	0.64	0.55
Post Training Respect Field Placement Supervisor	4.10	0.93	4.50	0.58	1.23
Post Training Genuineness Field Placement Supervisor	4.10	0.83	4.43	0.45	1.20
Pre Training Empathy - Self	3.86	0.64	3.83	0.61	0.12
Post Training Empathy - Self	4.15	0.52	4.44	0.46	1.49
Pre Training Respect - Self	4.00	0.72	4.44	0.58	1.79
Post Training Respect - Self	4.35	0.61	4.78	0.36	2.23*
Pre Training Genuineness - Self	4.11	0.58	4.22	0.36	0.63
Post Training Genuineness - Self	4.35	0.61	4.44	0.39	1.93

Note. Higher mean scores represent greater empathy, respect and genuineness

* $p < .05$

TABLE 9

TRAINEE RATINGS BY FIELD PLACEMENT SUPERVISORS

ITEM		MALES N=8 MEAN	MALES N=8 S D	FEMALES N=17 MEAN	FEMALES N=17 S D
1	Attendance	1.62	1.06	1.53	0.72
2	Work relationship with clients	1.37	0.74	1.35	0.61
3	Work relationship with supervisor	1.12	0.35	1.23	0.56
4	Work relationship w/other staff	1.37	0.74	1.53	0.72
5	Effort	1.25	0.46	1.47	0.62
6	Initiative and independence	1.37	0.74	1.53	0.72
7	Professional responsibility	1.63	1.06	1.65	0.86
8	Positive change in clients	2.00	1.07	1.87	0.99
9	Positive change in staff	2.29	0.95	2.41	1.18
10	Comfort in discussing sexuality with clients	1.25	0.46	1.24	0.56
11	Comfort in discussing sexuality with staff	1.43	0.79	1.13	0.34
12	Comfort with own sexuality	1.63	0.74	1.75	1.06
13	Knowledge of disability issues	1.38	0.52	1.41	0.80
14	Knowledge of sexuality	1.38	0.74	1.29	0.47
15	Knowledge of counseling	2.13	0.99	2.00	1.18
17	Counseling/education with clients	1.50	1.07	1.56	0.73
19	Level of experience as a counselor	2.13	0.99	2.56	1.27
28	Benefit to agency from trainees' activities	1.38	0.74	1.71	0.99
30	Satisfaction with trainees' activities	1.38	0.74	1.38	0.62
33	Carkhuff(Scale 1)Empathy	3.88	0.95	3.82	0.78
34	Carkhuff(Scale 2)Respect	3.94	0.82	4.39	0.84
35	Carkhuff(Scale 3)Genuineness	4.00	1.07	4.32	0.46
32	Was the trainee physically limited?	yes= 13	no= 10	partially= 2	
33	Did this physical limitation affect the trainees duties?	yes= 0	no= 10	partially= 5	

ce. Scoring for items 1-30 are: 1= most positive, 6= most negative
Scoring for Carkhuff Scales 1-3 are: 5= most positive, 1= most negative.

None of the above mean differences for males and females reach statistical significance.

TABLE 10

POST - TRAINING EMPLOYMENT SETTINGS OF PROJECT GRADUATES

3	teachers at community colleges
2	counselors at independent living agencies
	counselor and sex educator at a community college disabled student's program
	counselor at a county rehabilitation center and director of a disabled prisoners project
	counselor at Office of Civil Rights, H.E.W.
	counselor at V.A. Hospital, outreach project for disabled Viet Nam veterans
	counselor at residential center for disturbed adolescents
	counselor at private counseling center and executive director of a publicly funded service organization
	clinical services coordinator, Multiple Sclerosis Society
	physical therapist and sex counselor at an acute care hospital
	director of an independent living project
	director of a residential center for disturbed adolescents
	program services coordinator at Easter Seal Society
	sex educator-counselor at United Cerebral Palsy Association
	sex educator for a hospital-based project serving disabled children
	group leader for a gay, disabled men's group and director of an organization providing entertainment for patients at chronic care facilities
	film maker - writer and producer of a film that won a second place award at the 1979 International Rehabilitation Film Festival, New York, NY
	intern at a Multiple Sclerosis Society
6	graduates have returned to school to obtain master's degrees in counseling and psychology.

Note. The above indicators are more impressive when it is considered that some severely disabled graduates were in a financial bind, in that, by accepting a paying position, they could lose valuable Medi-Cal, attendant care, S.S.I. and Department of Rehabilitation support. These regulations are currently being challenged by various groups.

TABLE 11

FINAL EVALUATION OF TRAINING BY TRAINEES

ITEM	MALES N= 8 MEAN	MALES N= 8 S D	FEMALES N= 18 MEAN	FEMALES N= 18 S D
1. Health Aspects Course	5.38	0.92	4.33	1.65
2. Principles of Sex Counseling Course	5.38	0.74	5.59	0.62
3. Overall Didactics	4.75	0.71	4.78	1.06
4. Supervision	4.50	1.20	5.33	0.91
5. Large Group	5.00	0.54	4.94	1.16
6. Small Group	4.62	1.06	5.17	0.86
7. Sex and Disability Films	4.00	1.51	4.28	1.27
8. Research Paper	4.38	1.77	4.28	1.27
9. Personal Journal	2.87	1.55	3.33	1.50
10. Panel Presentations	5.38	0.74	5.61	0.70
11. Client Counseling	5.50	1.07	5.72	0.58
12. Trainee Interaction	5.50	0.54	5.17	1.20
13. Interaction with Staff # 1	5.13	0.64	5.39	0.85
14. Interaction with Staff # 2	4.25	1.16	4.89	1.02
15. Interaction with Staff # 3	5.37	0.74	5.72	0.57
16. Interaction with Staff # 4	4.25	1.28	4.28	1.32
17. Overall Course Content	4.62	0.74	4.60	1.06
18. Sexuality - Effectiveness	4.50	1.51	4.56	0.92
19. Sexuality - Time Allotted	2.00	0.58	1.60	0.63
20. Disability - Effectiveness	4.50	0.93	4.56	1.38
21. Disability - Time Allotted	1.75	0.46	1.47	0.52
22. Counseling - Effectiveness	4.62	1.19	4.17	1.34
23. Counseling - Time Allotted	1.25	0.46	1.27	0.46
24. Survey	3.67	0.82	4.27	1.10
25. Annon The Behavioral Treatment of Sexual Problems;Vol 1, Brief Therapy, 1974	5.12	0.84	5.12	0.99
26. Bach Creative Agression, 1974	3.83	1.60	4.18	1.33
27. Barbach For Yourself, 1975	4.43	1.27	5.06	1.11

TABLE 11 (CONT.)
-2-

ITEM	MALES N= 8 MEAN	MALES N= 8 S D	FEMALES N= 18 MEAN	FEMALES N= 18 S D
28. Belliveau & Richter, Understanding Human Sexual Inadequacy, 1970	4.00	1.20	4.83	1.15
29. Brecher & Brecher, An Analysis of Human Sexual Response, 1966	4.12	1.25	4.59	1.28
30. Fensterheim & Baer, Don't Say Yes When You Want to Say No, 1975	4.00	1.90	4.36	1.36
31. Gagnon, Human Sexualities, 1977	4.50	1.38	5.00	1.11
32. Mooney et al., Sexual Options for Paraplegics and Quadriplegics, 1975	4.50	0.54	4.79	1.12
33. Personal Benefit	5.63	0.74	5.28	1.13
34. Professional Benefit	5.25	0.71	5.00	0.97
35. Training Met Expectations (N= 25) YES= 12 (48.0%)				
PARTIALLY= 12 (48.0%)				
NO= 1 (4.0%)				

Note. Scoring for items 1-34 are: 6= most positive, 1= most negative; except that items 19, 21, 23 have: 1= not enough; 2= adequate; 3= more than enough.

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APPENDIX A

Other Training Activities of the Human Sexuality Program

Academic Teaching

Instruction of U.C.S.F. medical students in human sexuality began with an elective course in 1969, and was later made a required core curriculum offering in 1970. To date, over 2,500 medical, nursing, and other students have participated in the Human Sexuality in Medical Practice course (Psychiatry 180) and its precursor courses.

Continuing Education Type Teaching

The Human Sexuality Program has provided instruction to approximately 8,000 health care personnel during its six year history. This instruction has been provided principally by the Health Aspects of Human Sexuality course (and related courses) and the Introduction to Sex Counseling Principles course.

Sex Counseling Training and Clinical Services

The Sex Counseling Unit of the Human Sexuality Program has provided practicum training to more than 150 health care providers, including 22 M.D.'s, 31 Ph.D.'s, 52 M.A.'s, 21 M.S.W.'s, and 16 R.N.'s. As a direct result of this training activity, over 50,000 client contact hours of service have been provided to approximately 8,000 individuals.

APPENDIX B

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
SEX AND DISABILITY TRAINING PROJECT

REQUIRED READING

Annon, J., Behaviorial Treatment of Sexual Problems, Vol. 1, Kapiolani Health, 1975

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Brecher, E. and Brecher, R., An Analysis of Human Sexual Response, Signet, 1966

Fensterheim, H. and Baer J., Don't Say Yes When You Want to Say No, 1975

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Mooney, T., Cole, T., and Chilgren, R.. Sexual Options for Paraplegics and Quadriplegics, Little, Brown and Co., 1975

Woods, Nancy F., Human Sexuality in Health and Illness, C.V. Mosby Co., 1975

Zilbergeld, B., Male Sexuality, Little, Brown and Co., 1978

RECOMMENDED READING

Brecher, E., The Sex Researchers, Little, Brown and Co., 1969

Gordon, S., Living Fully, John Day Co., 1975

Greenburg, D., How to Make Yourself Miserable, Random House, 1966

Handman, H. and Brennan, P., The Sex Handbook: Information and Help for Minors, Putnam, 1974

Tennov, D., Psychotherapy: The Hazardous Cure, Anchor Press/Doubleday, 1976

Kubler-Ross, E., On Death and Dying,

APPENDIX C

CONSULTANTS: 11/76 to 11/77

Consultant	Date	Topic
Joshua Golden, M.D.	11/16/76	Sex Counseling and Disability
Wardell Pomeroy, Ph.D.	11/30/76	Sex History-taking: Coding and Interviewing
Robert Belnap, M.D.	11/23/76	Humanistic Medicine
Bernie Zilbergeld, Ph.D.	12/ 7/76 7/26/77	Brief Therapy
Don Linker, M.D.	1/11/77	Urology and Implants
George Fuller, Ph.D.*	1/11/77	Biofeedback
Peter Leech, M.S.W.*	1/26/77 8/24/77	Peer Counseling
Judith Botsford, R.N., M.S.*	1/26/77 8/ 3/77	Contraception; Venereal Disease
Lois Dolan	2/ 1/77	Sexual Trauma and Rape
Sadja Goldsmith, M.D.	11/ 2/77	Ob-Gyn Concerns; Mastectomy
Gay Blackford, R.N., M.S.*	2/15/77	Sexuality and Medical Concerns
Delee Lanz, Ph.D.*	2/16/77	Biofeedback, Sex and Rehabilitation
Linda Alperstein, L.C.S.W.*	1/25/77 2/ 1/77 2/ 8/77	Assertiveness Training
Russell Blanchard, M.D.*	3/ 1/77	Hypnosis
Rita and Lorne Bay*	3/ 7/77 9/30/77	Touch and Sensate Focus
Cindy Gatens, R.N., M.S.*	3/15/77	Sexuality and Spinal Cord-Injured Women
Winifred Kempton, M.S.*	4/19/77	Sex Education and the Mentally Retarded
Alan Newman, M.D.	5/ 3/77 7/20/77	Sex Counseling and Quality of Life for Terminally Ill Cancer Patients
Judy Sobieski, R.N.*	7/27/77	Effects of Genital Surgery on Female Sexuality

Consultant	Date	Topic
Joani Blank, M.A.*	8/ 2/77	Vibrators and Assistive Devices
Victor Alter*	8/ 2/77	Ostomies: Effects on Sexual Functioning
Bhima Islas	8/ 9/77	Enlightenment Intensives
Elaine Gutstadt, M.S.W.*	3/16/77 8/10/77	Discussion of Hospice of Marin Program for Terminally Ill
Frank Moore* Nina Feldman*	8/16/77	Discussion of Counseling Approach
Marcia Krawll	8/17/77	Suicide Prevention Counseling
Jay Mann, Ph.D.	8/23/77	Family Relationships and Therapy
Karen Schanche*	8/23/77	Preorgasmic Groups for Disabled Women
Stuart Heller*	8/30/77	Relaxation; Alexander Technique
Jean Stoklosa, R.N. John Good, M.D.	9/ 6/77	Health Systems Research and Planning Group
Gloria Blum, M.A.*	3/22/77 9/ 7/77	Communication and Assertiveness for the Disabled
James Burger, M.A.	8/31/77	Sexuality Education and Counseling for Mentally Retarded
Art Bodin, Ph.D.*	9/27/77	Couples: Conflict, Counseling and Change
Barbara Moehrlin, R.N.*	9/28/77	Sex and Aging
Lynn Segal, M.S.W.*	10/ 5/77	Brief Therapy
Carrie Frazier, M.S.W.*	3/16/77 10/12/77	Renal Disease, its Treatment - and Sexuality
Carol Johnston*	10/19/77	Arthritis
Robert Badame, Ph.D. Cand. Linda Gore, M.A.	10/25/77 11/ 1/77	Social Skills Training

* Consultants paid with Sex and Disability Training Project grant money

FIELD PLACEMENTS UTILIZED

1. Alpha Place
   San Jose, CA
2. Ann Arbor Center for Independent Living
   Ann Arbor, MI
3. Arthritis Center
   University of California Medical Center
   San Francisco, CA
4. California Regional Spinal Cord Injury Center
   Santa Clara Valley Medical Center
   San Jose, CA
5. Cancer Research Institute
   University of California Medical Center
   San Francisco, CA
   (3 trainees)
6. Center for Independent Living
   Berkeley, CA
7. Children's Hospital
   Oakland Center for Multiple Handicaps
   Oakland, CA
8. Community Resources for Independence
   Santa Rosa, CA
9. Crystal Springs Rehabilitation Center
   San Mateo County Department of Public Health and Welfare
   San Mateo, CA (2 trainees)
10. Eden West Rehabilitation Hospital
    Hayward, CA
11. Independent Living Project
    San Francisco, CA
    (4 trainees)
12. Kaiser Rehabilitation Center
    Vallejo, CA
13. Mt. Diablo Rehabilitation Center
    Pleasant Hill, CA
14. Physically Disabled Students' Program
    California State University
    Hayward, CA
    (2 trainees)
15. Physically Disabled Students' Program
    University of California
    Berkeley, CA

16. Physically Limited Students' Center
    Chabot College
    Hayward, CA
    (3 trainees)

17. Planned Parenthood
    Sacramento, CA

18. Ralph K. Davies Medical Center
    Rehabilitation Center
    San Francisco, CA

19. Recreation Center for the Handicapped
    San Francisco, CA
    (4 trainees)

20. Skills Center
    Santa Cruz, CA

21. Veteran's Administration Hospital
    San Francisco, CA

22. Vista College
    Berkeley, CA

23. Westside Community for Independent Living
    Los Angeles, CA

DIDACTIC PHASE

SUGGESTED CURRICULUM

TOPIC OUTLINE	TECHNIQUES	INSTRUCTOR/S
I - Health Aspects of Human Sexuality		
A. Introduction-Overview of course process	Lecture	HSP* staff
B. Human sexual response cycle-based on Masters and Johnson's research	Lecture, slides	S&D** staff
C. Multiple sexual value systems in our society	Panel discussions, films, lecture	HSP staff S&D staff
D. Importance of fantasy and language in sexual development	Films, audio tape	
E. Reactions and feelings to panel participants, films, and other course content	Small group discussion	S&D staff
II- Health Aspects of Human Sexuality		
A. Introduction to learning theory of human sexual development	Lecture, panel discussion	HSP staff S&D staff
B. Common sexual concerns and counseling modalities	Lecture, film	HSP staff
C. The effects of aging on sexual response	Lecture, film	HSP staff
D. Touch and sensate focus as it relates to sexuality	Lecture, demonstration	HSP staff
E. Individual responses to course content; learning to acquire sex information through history-taking format	Small group discussion, co-counseling dyads	S&D staff
III-Health Aspects of Human Sexuality		
A. An overview of medical conditions and sexual concerns	Lecture	S&D staff
B. Introduction to sex and disability	Lecture, panel discussion	S&D staff

*Human Sexuality Program Staff
**Sex and Disability Staff (Bullard, Rodocker, Knight and three disabled paraprofessionals)

	TOPIC OUTLINE	TECHNIQUES	INSTRUCTOR/S
C.	Discussing sexual concerns with patients/clients in health care settings	Panel discussion	HSP staff S&D staff
D.	Identifying and discussing specific sexual concerns	Small groups, role-playing	S&D staff
	IV- Congenital Disabilities: Educational and Counseling Aspects		
A.	Some common components of congenital disability and how it affects socio/sexual development. Short stature: common types, frequency of occurence, social misconceptions, special needs, specific sexual concerns	Lecture, large group discussion	S&D staff
B.	Common congenital disabilities such as cerebral palsy, spina bifida, muscular dystrophy and similarities in socio/sexual development. Pertinent issues include stigma, social isolation, sterotypes.	Small group discussion	S&D staff
C.	The "PLISSIT" model: explanation and practice in giving permission and limited information	Lecture, dyads	S&D staff
D.	Issues arising during counseling of a disabled adult with cerebral palsy who has a speech impairment	Role play, video-tape feedback	S&D staff
E.	Anatomy and physiology of spinal cord injury as it relates to sexual functioning	Lecture, charts	S&D staff/ Medical Director
	V- Disabilities Affecting Physiology of Sexual Response Cycle/Educational and Counseling Aspects		
A.	Genital surgery following cancer of uro-genital tract--alterations in blood and nerve supply, changes in body image, use of mechanical assistive devices, psychological and social implications	Lecture, group discussion	Consultant/ S&D staff
B.	Spinal cord injury (con't) emphasis on body image changes, relationship concerns, social and structural barriers	Small group discussion, role play	S&D staff/ Medical Director
C.	The "PLISSIT" model (con't) explanation and practice of giving specific suggestions	Lecture, role play, video-tape feedback	S&D staff
D.	Integration of specific communication skills such as active listening and values clarification	Small group discussion, Co-counseling	S&D staff

	TOPIC OUTLINE	TECHNIQUES	INSTRUCTOR/S
E.	Introduction to network concept: listing of geographic areas, available local resources, economic considerations	Lecture, large group discussion	S&D staff
	VI- Social Skills Development		
A.	Introduction to program: purpose and importance of self-responsibility	Lecture	Consultant (Badame), S&D staff
B.	Basic communication skills: non-verbal and verbal	Lecture, dyad exercise	"
C.	Dealing with "martyr" or "poor me" syndrome	Lecture, role play, demonstration	"
D.	Body language and its messages	Demonstration	"
E.	Small talk and compliments	Dyad exercise	"
F.	Sharing vulnerabilities via "secrets"	Large group exercise	"
G.	Utilization of homework assignments--examples presented and assigned	Lecture	"
	VII-Social Skills Development		
A.	Review of day VI and report on homework assignments	Discussion	Consultant (Badame)/ S&D staff
B.	Discounting oneself and various aspects of rejection	Role play, Demonstration	"
C.	Expression and utilization of acceptance	Dyad exercise, large group discussion	"
D.	Conditions: how one determines components of a situation which is comfortable	Role play, large group exercise	"
E.	Anger and intimacy	Role play, dyad exercise, demonstration	Consultant/ S&D staff
F.	Control and power--negative and positive consequences	Case presentation, role play, discussion	"
G.	Critique of social skills content and practice sessions	Anonymous written evaluation	
	VIII-Contraception, Venereal Disease, Sexuality and Disabled Women		
A.	Reliable methods of birth control with special consideration for disabled women: includes methods available, effectiveness and possible side effects, individual values about different methods	Lecture, demonstration	Consultant

	TOPIC OUTLINE	TECHNIQUES	INSTRUCTOR/S
B.	Definition of venereal disease, main types, transmission, symptoms, testing, complications, treatment, methods of prevention, social stigma	Lecture	Consultant
C.	Importance of being able to communicate about sex and birth control; communication issues about avoiding V.D. infection or seeking treatment if needed	Small group discussion, Co-counseling	S&D staff
D.	Decision making process about use of contraception; how disabled woman presents needs to partner	Large group discussion role play, video-tape feedback	S&D staff
E.	Disabled women and gynecological care, pregnancy, child-rearing, divorce, social stereotypes	Lecture/discussion	S&D staff
	IX- Medical Ramifications in Sexual Counseling		
A.	Common female and male sexual concerns and treatment approaches	Lecture	Consultants (Caplan, Black)
B.	Couple counseling, sexual concerns, and communication issues	Lecture, role play	"
C.	Sexual adaptation to hospitalization and illness	Lecture	"
D.	Effects of surgery and/or chronic illness on sexual functioning	Lecture, case presentation	"
E.	Drug-related side effects on sexual functioning	Lecture	"
F.	Educational and counseling issues pertaining to altered states of health; changes in sensation, mobility, ability to achieve orgasm, body image and self-esteem	Lecture, role play case presentations	"
	X- Training Day: Two Options		
A.	Sensate Focus Workshop	Demonstration, dyad exercise	Consultant
B.	Library research/course reading		
	XI- Disabilities and Body Image		
A.	Sexuality and ostomies; fears, misconceptions, partner concerns, specific sexual dysfunctions, mechanical assistive devices, communication issues	Lecture, discussion	Consultant S&D staff

	TOPIC OUTLINE	TECHNIQUES	INSTRUCTOR/S
B.	Responding to body image and self-esteem concerns; includes personal sharing, validation, active listening, feedback	Co-counseling dyads, discussion	S&D staff
C.	Methods for presenting common disability and sexuality concerns to health professionals and allied workers. Effectiveness of lecture format, panel presentations, small group discussion, films	Video-tape, discussion	S&D staff
D.	Peer counseling: definition, rationale, when used, effectiveness, training, special considerations	Lecture, discussion	S&D staff
	XII-Sexuality, Progressive Chronic Disabilities, Terminal Illness		
A.	Renal disease--medical and social aspects, effects on sexual functioning, changes in self-esteem as a result of male/female role changes	Lecture, discussion	Consultant S&D staff
B.	Other progressive disabilities such as multiple sclerosis: effects of "unpredictability" aspects on self-image, interpersonal relationships	Discussion, role play, case presentations	S&D staff
C.	Terminal illnees: alienation, despair, lack of touch and feelings of isolation, family concerns, learning to communicate openly and effectively	Lecture, discussion	S&D staff
	XIII-Integration of Sex and Disability Services into Health Care Settings		
A.	Health systems research and planning: description of different settings, common obstacles to gaining entrance, economics, hierarchy of personnel, effective approaches for enlisting support and provoking interest	Lecture, discussion	Consultant S&D staff
B.	Family dynamics: roles, interpersonal behaviors, use of "objective" intermediary. Compare and contrast some components of family interactions to those found in health settings among various staff members	Lecture, role play, discussion	Consultant S&D staff
C.	Introducing Sex and Disability workshop as part of inservice education: format, content, presentation methods	Video-tape, discussion	S&D staff

TOPIC OUTLINE	TECHNIQUES	INSTRUCTOR/S
XIV and XV - Group Network Planning		
A. Regional group network concept: geographical areas, transportation, economics, existing resources, types of agencies involved, populations served and unserved, unmet needs for S&D services	Small group discusssions	S&D staff
B. Network plan development: inservice and community workshop planning, establishing counseling services and a consultant network, sharing regional resources	Small and large group discussions	S&D staff
C. Regional exchange of program development for selected areas: ideas for implementation, funding sources, publicity (outreach), transportation assistance, development of regional educational plan	Case presentation	Regional representatives
XVI- Evaluation and Closure		
A. Summary and evaluation of practicum experience (trainee mock counseling sessions with disabled paraprofessional staff)	Discussion	S&D staff
B. Review of topics covered and questions related to any of those topics	Discussion	S&D staff
C. Determine future topic areas of interest or those topics participants feel need more coverage	Discussion	S&D staff
D. Feedback from participants	Anonymous evaluation forms	
E. Closure: staff and participants share reactions to past weeks discussing personal and professional impact	Discussion	S&D staff

PRACTICUM PHASE

TOPIC OUTLINE	TECHNIQUES	INSTRUCTOR/S
I		
A. Sex and disability topic requested by trainees at closure of two week intensive	Lecture, discussion	S&D staff
B. Reports on trainee agency activities listed in behavioral contract, including inservice presentations, client contact, staff consultation, referral needs. Staff and trainee feedback.	Lecture, discussion	Trainees S&D staff
C. Evaluation of two week intensive from four month perspective	Discussion	S&D staff
D. Review of reading assignments	Discussion	S&D staff
II		
A. Mock presentations of topic areas to be presented at regional workshops (Weekend II), e.g. spinal cord injury rap, sexuality and medical conditions, contraceptive issues, etc.	Lecture	Trainees
B. Critique of mock presentations	Video tape, discussion	S&D staff Trainees
C. Inservice training "checklist": review of operational plan for regional workshops	Lecture, discussion	S&D staff
D. How to provide information and referral requested by workshop participants on an individual basis	Discussion, Co-counseling	S&D staff
III		
A. Regional workshop for professionals, paraprofessionals, and consumers	Lecture, panel presentations, films, discussion	Trainees S&D staff

TOPIC OUTLINE	TECHNIQUES	INSTRUCTOR/S
IV		
A. Evaluation of workshop: review of participant feedback, self and group critique	Discussion	S&D staff
B. Reports on trainee agency activities listed in behavioral contract of previous four months. Staff and trainee feedback	Lecture, discussion	Trainees S&D staff
C. Sex and disability topic requested by trainees	Lecture, discussion	S&D staff
D. Review of reading assignments	Discussion	S&D staff
V		
A. Reports on trainee agency activities of previous four months. Staff and trainee feedback	Lecture, discussion	Trainees S&D staff
B. Some termination issues: loss, anger, denial, resolution	Lecture, discussion	S&D staff
C. Development of two-year regional plans	Lecture, small group discussion	S&D staff trainees
D. Review of reading assignments	Discussion	S&D staff
VI		
A. Review of years activities, evaluation of overall training	Trainee and staff ratings, questionnaires, etc., discussion	S&D staff
B. Impact of training both personally and professionally	Discussion	Trainees S&D staff
C. Unfinished business and closure	Discussion	S&D staff

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SEX AND DISABILITY TRAINING PROJECT

Wednesday, December 7, 1977

10:30 Didactic: Lonnie G. Barbach, Ph.D. "Pre-Orgasmic Groups for Women"

12:00 Field Placement Supervision Groups/Lunch

1:45 Large Group: Scheduling trainee presentations
Report on Masters and Johnson conference
Assign case presentation for next week

2:30 Break

3:00 Role playing (David's client; ½ hour)

4:30 Small Groups

6:00 close

Wednesday, December 14, 1977

10:30 Large Group

11:00 Small Groups

12:30 Didactic: Karen Boggs, R.N., M.S. "Sexuality and Cardiac Care"

2:00 Field Placement Supervision/Lunch

3:30 Break

4:00 Didactic: Bob Geiger, M.D. "Pain Management"

5:00 Case presentation/ Role playing

6:00 close

(Outline)

Field Placement Report

Sex and Disability Training Project

Name_____

1. Name and address of facility
2. Dates of field placement
3. Description of facility

    Population served; immediate community

    Services

    Staff

4. Description of facilities resources for socio-sexual education and counseling prior to trainee's placement
5. Needs assessed by trainee
6. Description of trainee activities
7. Description of supervision
8. Evaluation of trainee activities

    Impact on residents/clients/patients

    Impact on staff

    Long range impact

9. Recommendations as to resources needed in future
10. Summary of trainee's personal experience in field placement

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

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DEPARTMENT OF PSYCHIATRY
HUMAN SEXUALITY PROGRAM

Administrative and Research Offices
350 Parnassus Avenue — Suite 700
San Francisco, CA 94143
(415) 666-4787 ☐

Counseling Unit
350 Parnassus Avenue — Suite 300
San Francisco, CA 94143
(415) 666-4623 ☐

Sex and Disability Unit
814 Mission Street — Second Floor
San Francisco, CA 94103
(415) 666-1066 [X]

SEX AND DISABILITY TRAINING PROJECT

TRAINEE EVALUATION QUESTIONNAIRE

Please circle or fill in the appropriate response.

Trainee _____ Period of Field Placement _____ to _____

Supervisor _____ Agency (Field Placement) _____
(and Questionnaire respondant)

_____

1. How satisfied are you with the trainee's attendance at the field placement?
   1 - Extremely satisfied
   2 - Moderately satisfied
   3 - Fairly satisfied
   4 - Fairly dissatisfied
   5 - Moderately dissatisfied
   6 - Extremely dissatisfied

2. How would you describe the trainee's work relationships with clients/patients/residents?
   1 - Very appropriate
   2 - Fairly appropriate
   3 - Somewhat appropriate
   4 - Somewhat inappropriate (please briefly describe)
   5 - Fairly inappropriate (please briefly describe)
   6 - Very inappropriate (please briefly describe)

3. How would you describe the trainee's work relationship with you?
   1 - Very appropriate
   2 - Fairly appropriate
   3 - Somewhat appropriate
   4 - Somewhat inappropriate (please briefly describe)
   5 - Fairly inappropriate (please briefly describe)
   6 - Very inappropriate (please briefly describe)

4. How would you describe the trainee's work relationships with other staff?
   1 - Very appropriate
   2 - Fairly appropriate
   3 - Somewhat appropriate
   4 - Somewhat inappropriate (please briefly describe)
   5 - Fairly inappropriate (please briefly describe)
   6 - Very inappropriate (please briefly describe)

5. How much effort do you feel the trainee put into his/her field placement activities?
   1 - A great deal
   2 - A fair amount
   3 - Somewhat
   4 - Very little
   5 - None at all

6. How much did the trainee demonstrate initiative and independence in thought and action?
   1 - A great deal
   2 - A fair amount
   3 - Somewhat
   4 - Very little
   5 - None at all

7. How much professional responsibility did the trainee exhibit toward his/her activities?
   1 - Considerable
   2 - A moderate amount
   3 - A fair amount
   4 - Somewhat
   5 - Very little
   6 - None at all

8. How much positive change occurred in clients/patients/residents as a result of trainee's activities?
   1 - A great deal
   2 - A fair amount
   3 - Somewhat
   4 - Very little
   5 - None at all

9. How much positive change occurred in staff as a result of trainee's activities?
   1 - A great deal
   2 - A fair amount
   3 - Somewhat
   4 - Very little
   5 - None at all

10. How comfortable do you feel trainee is in discussing sexual topics with clients/patients/residents?
   1 - Very comfortable
   2 - Fairly comfortable
   3 - Somewhat comfortable
   4 - Somewhat uncomfortable
   5 - Fairly uncomfortable
   6 - Very uncomfortable

11. How comfortable do you feel trainee is in discussing sexual topics with staff?
   1 - Very comfortable
   2 - Fairly comfortable
   3 - Somewhat comfortable
   4 - Somewhat uncomfortable
   5 - Fairly uncomfortable
   6 - Very uncomfortable

12. How comfortable do you feel trainee is with his/her own sexuality?
    1 - Very comfortable
    2 - Fairly comfortable
    3 - Somewhat comfortable
    4 - Somewhat uncomfortable
    5 - Fairly uncomfortable
    6 - Very uncomfortable

13. How would you describe trainee's knowledge of issues in disability?
    1 - Very knowledgeable
    2 - Fairly knowledgeable
    3 - Somewhat knowledgeable
    4 - Somewhat unknowledgeable
    5 - Fairly unknowledgeable
    6 - Very unknowledgeable

14. How would you describe trainee's knowledge of issues in sexuality?
    1 - Very knowledgeable
    2 - Fairly knowledgeable
    3 - Somewhat knowledgeable
    4 - Somewhat unknowledgeable
    5 - Fairly unknowledgeable
    6 - Very unknowledgeable

15. How would you describe trainee's knowledge of counseling techniques?
    1 - Very knowledgeable
    2 - Fairly knowledgeable
    3 - Somewhat knowledgeable
    4 - Somewhat unknowledgeable
    5 - Fairly unknowledgeable
    6 - Very unknowledgeable

16. Everything considered, how satisfied are you with the results of the trainee's inservice training for the staff on sexuality and disability?
    1 - Extremely satisfied
    2 - Moderately satisfied
    3 - Somewhat satisfied
    4 - Somewhat dissatisfied
    5 - Moderately dissatisfied
    6 - Extremely dissatisfied
    7 - (No inservice was presented by trainee)

17. Everything considered, how satisfied are you with the results of the trainee's counseling/educational activities with clients/patients/residents?
    1 - Extremely satisfied
    2 - Moderately satisfied
    3 - Somewhat satisfied
    4 - Somewhat dissatisfied
    5 - Moderately dissatisfied
    6 - Extremely dissatisfied
    7 - (No counseling/educational activities were presented by trainee)

18. To what extent do you feel trainee represented his/her level of skills and abilities to others?
    1 - Extremely overexaggerated
    2 - Rather overexaggerated
    3 - Accurately
    4 - Rather underexaggerated
    5 - Extremely underexaggerated

19. What impression do you have of the trainee's level of experience as a counselor?
    1 - Highly experienced
    2 - Fairly experienced
    3 - Somewhat experienced
    4 - Somewhat inexperienced
    5 - Fairly inexperienced
    6 - Highly inexperienced

Please indicate to what extent each of the following statements describes your view of the trainee's counseling skills. Disregard that at one point or another in supervision you may have felt differently. Use the following code and circle your answer.

2 Strongly agree
1 Mildly agree
0 Undecided
-1 Mildly disagree
-2 Strongly disagree

20.	2	1	0	-1	-2	The trainee almost never used technical terms in counseling sessions.
21.	2	1	0	-1	-2	There were times when clients experienced intense anger toward the trainee.
22.	2	1	0	-1	-2	I feel the trainee was rather active most of the time.
23.	2	1	0	-1	-2	I am convinced that the trainee respected his/her clients as persons.
24.	2	1	0	-1	-2	I feel the trainee was genuinely interested in helping clients.
25.	2	1	0	-1	-2	Clients were often made to feel they were "just another client" by the trainee.
26.	2	1	0	-1	-2	The trainee was always keenly attentive to what clients had to say.
27.	2	1	0	-1	-2	The trainee often used very abstract language.

28. How much do you feel your agency has benefitted as a result of the trainee's field placement?
    1 - A great deal
    2 - A fair amount
    3 - Somewhat
    4 - Very little
    5 - Not at all

29. Describe the most important changes above:

30. Everything considered, how satisfied are you with the results of the trainee's field placement experience?
    1 - Extremely satisfied
    2 - Moderately satisfied
    3 - Fairly satisfied
    4 - Fairly dissatisfied
    5 - Moderately dissatisfied
    6 - Extremely dissatisfied

31. What are one or two critical incidents that are supportive of your response?

32. At the completion of the trainee's field placement, how will his/her activities be continued by the agency?
    1 - Other staff will continue all activities
    2 - Other staff will continue some of the activities; some will not be continued
    3 - Activities will not be continued (with present agency resources)
    4 - Other:

33. Was the trainee physically limited? yes____ no____ partially____

34. If yes to above, has this affected trainee's duties? yes____ no____ partially____

    How?

35. Please indicate the adequacy of this questionnaire in describing the field placement experience from your point of view. Give any additional data which you feel are relevant to an understanding of your experience as a supervisor.

Scale 1
EMPATHIC UNDERSTANDING IN INTERPERSONAL PROCESSES

The therapist communicates no awareness of even the most obvious, expressed surface feelings of the client. The therapist may be bored or uninterested or simply operating from a preconceived frame of reference which totally excludes that of the client. — LEVEL 1

(The therapist functions somewhere between LEVEL 1 and LEVEL 2). — LEVEL 1.5

The therapist may communicate some awareness of obvious surface feelings of the client, but the communications of the therapist drain off a level of the affect and distort the level of meaning. The therapist may voice opinions of what may be going on, but these are not congruent (identical) with the expressions of the client. — LEVEL 2

LEVEL 2.5

The therapist responds with accurate understanding of the surface feelings of the client but may not respond to or may misinterpret the deeper feelings. — LEVEL 3

LEVEL 3.5

The therapist is a facilitator who communicates understanding of the expressions of the client at a level deeper than they were expressed, and thus enables the client to experience and/or express feelings he was unable to express previously. — LEVEL 4

LEVEL 4.5

The therapist as facilitator responds with accuracy to all of the client's deeper as well as surface feelings. The therapist is "together" with the client or "tuned in" on the same wave length as the client. — LEVEL 5

Scale 2
THE COMMUNICATION OF RESPECT IN INTERPERSONAL PROCESSES

(Circle one)

The therapist communicates to the client that the client's feelings and experiences are not worthy of consideration or that the client is not capable of acting constructively. The therapist may become the sole focus of evaluation.	LEVEL 1
(The therapist functions somewhere between LEVEL 1 and LEVEL 2).	LEVEL 1.5
The therapist may respond mechanically or passively or ignore many of the feelings of the client.	LEVEL 2
	LEVEL 2.5
The therapist communicates respect and concern for the client's ability to express himself and to deal constructively with his life situation.	LEVEL 3
	LEVEL 3.5
The therapist as facilitator responds in such a way as to enable the client to feel free to be himself and to experience being valued as an individual	LEVEL 4
	LEVEL 4.5
The therapist as facilitator cares very deeply for the human potentials of the client.	LEVEL 5

SCALE 3
FACILITATIVE GENUINENESS IN INTERPERSONAL PROCESSES

(Circle one)

The therapist may be defensive in interacting with the client and this defensiveness may be demonstrated in the content of the therapist's words. This defensiveness by the therapist is not a basis for potentially valuable inquiries into the relationship. — LEVEL 1

(The therapist functions somewhere between LEVEL 1 and LEVEL 2). — LEVEL 1.5

The therapist may respond to the client in a "professional" manner that has a rehearsed quality or a quality concerning the way a helper "should" respond in that situation. — LEVEL 2

LEVEL 2.5

The therapist may listen and follow the client but commits no personal involvement. — LEVEL 3

LEVEL 3.5

The therapist as facilitator expressed his own true feelings, although he may be somewhat hesitant about expressing them fully. — LEVEL 4

LEVEL 4.5

The therapist as facilitator is completely spontaneous in interacting with the client and is open to experiences of all types, both pleasant and hurtful. In the event of hurtful responses the facilitator's comments are employed constructively to open a further area of inquiry for both the facilitator and the client. — LEVEL 5

APPENDIX H

MEMORANDUM OF UNDERSTANDING

BETWEEN

_____

AND

SEX AND DISABILITY UNIT
HUMAN SEXUALITY PROGRAM
DEPARTMENT OF PSYCHIATRY
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

This cooperative relationship between _____ and the Sex and Disability Unit, Human Sexuality Program, is agreed to for purposes of education and training, from January 31, 1978 to January 24, 1979.

To fulfill the responsibility and obligations of being a trainee in the Sex and Disability Unit, _____ agrees:

1) To attend all regularly scheduled training sessions as follows:

"Health Aspects of Human Sexuality" course, February 10--12, 1978;
"Introduction to Sex Counseling Principles" course, April 28--30 & May 5--7, 1978.

Didactic Phase: January 31, 1978, through June 28, 1978. Tuesdays and Wednesdays (eight hours per day), meeting with other trainees and staff for training and supervision. Additional home assignments (four hours per week), including reading and projects. Total = 20 hours per week.
Practicum Phase: July 19, 1978, through January 24, 1979. A total of one to one-and-half days per week (8--12 hours per week) at a placement agency; specific days and/or evenings to be mutually decided between trainee, placement staff, and Unit supervisor. Additional one day per week (Wednesdays) training and supervision with trainees and staff. Additional home assignments (up to four hours per week). Total = 20 hours per week.

In addition to the above, some weekends (not to exceed three) and some evenings (not greater than two per week) may be scheduled as needed.

Exceptions to the above are the following vacation days:
March 21 & 22, 1978 (Easter)
July 4, 5, 11 & 12, 1978 (Summer/Fourth of July)
November 22, 1978 (Thanksgiving)
December 20 & 27, 1978 (Christmas and New Year)

2) That if any regularly scheduled days, evenings or weekends are missed by the trainee, his or her small group leader will decide whether it is an excused or unexcused absence. Missing more than 20% of regular training days (excused or unexcused) will be grounds for probation or dismissal from the Project.

3) To complete and hand in as requested by staff:

a) Individual or small group research project or materials development.
b) Paper on sexual concerns of people with a specific disability (study group paper).
c) Report on field placement experience.
d) Personal journal with weekly entries to be handed in as requested by staff.
e) Final report of personal reaction to training.

4) To participate or decline to participate in small group activities accrding to the stated guidelines (see page 5).

5) To participate in evaluation activities as requested by staff. (The Sex and Disability Unit is mandated by NIMH to evaluate the effectiveness of the training program. Evaluation will also serve as an educational experience for trainees.) Trainees do, however, retain the right to refuse to participate in this aspect of the training program at any time.

6) To participate as a panelist presentor or small group leader in a minimum of two educational programs (workshops) as scheduled and presented by the Sex and Disability Unit or by the Human Sexuality Program. This will be done without compensation to the trainees other than travel reimbursement and, when possible, eating expenses. $50 to $100 will be paid to each trainee for each program beyond the third program in which the person has participated as a trainee. These workshops may be given on weekends and participation will be considered an integral part of the training program. Programs given at a trainee's field placement will be done without payment, either to the trainee or to the Sex and Disability Unit, or to the Human Sexuality Program, unless this has been agreed upon by the trainee, placement facility, and the staff of the Sex and Disability Unit. Trainees will be utilized on a priority basis for programs sponsored by the Unit; the Unit reserves the right, however, to use other persons who have special expertise or life-situation qualifications when necessary.

7) To be responsible for, and to complete, records as required at field placement settings and in the U.C. clinic.

8) To be responsible for having a cassette tape recorder available for his/her own use in taping all sessions with clients.

9) To abide by relevant rules and procedures as specified in the Procedure Manual of the Human Sexuality Program, including:

Public Relations Concerns: Since the effective management of public relations is a sensitive issue for the Program as a whole, no interviews or information will be released or approved for release to the media unless cleared through proper University channels (this pertains to information regarding the program, or to your role as trainee). If you have a request, or are approached by the media, please refer the person or media to the Associate Director of the Sex and Disability Unit, or to the Director/Acting Director of the Human Sexuality Program.

Status While In Training: Name tags are to be supplied by the Program, and are to be worn on clinic days and at any other official activities of the Program. This is a requirement of the University, and is related to the clients' right to be informed about who is delivering services. It is appropriate to be clear with clients that we are basically a teaching institution, and through teaching we offer services to the public.

Official Designation While In Training Will Be "Counselor Trainee." Please represent yourself as such to the general public.

To fulfill its responsibility and obligations, the Sex and Disability Unit agrees:

1) To provide training and supervision in the areas of sexuality, disability, and counseling.

2) To provide supervision, including the use of direct observation, audio tapes, Associate Staff of the Human Sexuality Program (in the role of co-preceptor), and peer feedback from other trainees.

3) To contract to have qualified consultants (including Associate Staff) give didactic presentations in specialty areas.

4) To utilize trainees' experience, training, and skills in the didactic sessions whenever applicable.

5) To waive the tuition fee of $3500 for this year-long training experience.

6) To reimburse trainees for mileage (or bus fare) at approximately 12¢ per mile for travel to and from practicum agencies, within the budget limitations of the grant. Trainees traveling or commuting from outside of the Bay Area will be unable to collect the full mileage rate.

7) To cooperate fully with trainees who are seeking undergraduate or graduate credit for the training.

8) To provide assistance in finding employment in the area of counseling and rehabilitation for trainees who have successfully completed the training.

9) To provide a letter of recommendation for each trainee upon completion of the training, based on their evaluations during training.

10) To consider trainees' preferences for field placement agencies together with the needs and preferences of the individual agencies. Final decisions will be made by Unit staff.

11) To grant a partial stipend of $_____ to _____ to help defray expenses for books and other travel expenses related to the training.

Mutual Terms:

1) The Liaison Committee will consist of two trainees selected by the trainee group, and two members of the Sex and Disability Unit Staff. This committee will be available to discuss any issues related to the training procedure, requirements, or staff/trainee relations; and will be able to propose amendments or changes in the Memorandum of Understanding. Three-quarter vote of this Committee will be necessary to amend the Memorandum. Appeal of the decisions of this Committee can be made by a member of this Committee to an Appeals Committee consisting of the Director/Acting Director of the Human Sexuality Program, one faculty member of U.C.S.F. Medical School (not in the Human Sexuality Program), and one disabled person active in a community organization. The specific people to be appointed to the Appeals Committee (with the exception of the Director/Acting Director of the Human Sexuality Program) will be decided

by the Liaison Committee. Decisions of the Appeals Committee will be considered final.

2) Trainees and staff of the Sex and Disability Unit agree that trainees will be individually evaluated according to the following criteria: attendance and participation in small and large group process; pre/post knowledge inventories; peer, staff and client assessments; evaluations by placement agency personnel; required reports, research projects, or materials development; feedback from workshop participants. Each trainee will receive formal evaluation from staff of his/her progress in training every four months. Less formal feedback will be a constant part of the training process.

3) Formal evaluation of training and supervisory staff by trainees will be done every four months. Less formal feedback will be a constant part of the training process.

4) Each trainee will be on "probationary status" for the first four months of training. During the first formal evaluation in June, 1978, staff will determine whether full trainee status, continued probation, or dismissal from the program, will be accorded the trainee. This decision will be made according to the criteria outlined in Section Two, Mutual Terms (above), and elsewhere in this Memorandum of Understanding. This decision may be appealed directly by the trainee to the Appeals Committee. The status of a trainee who continues on probation beyond the first four months will be reviewed monthly by the staff and the trainee.

5) Trainees will have the primary responsibility for investigating potential field placement sites for themselves; assistance in this will also be provided by staff.

6) All final evaluation materials are to be handed in prior to February 15, 1979. All final trainee reports and papers requested by staff are to be handed in prior to February 28, 1979. Trainee's status with the Project will be permanently designated as "Incomplete" if the above dates have not been complied with, unless otherwise agreed upon by staff.

7) This Memorandum of Understanding may be terminated by the trainee at any time. Staff can terminate this Memorandum of Understanding with an individual who has not complied with the terms stated herein and who is on probation. This decision can be appealed by the trainee to the Liaison Committee (excluding that particular trainee if serving on the Committee) or to the Appeals Committee. Whoever terminates this agreement shall set forth the reasons in writing, and submit them to David G. Bullard, Ph.D.

_____	_____
Counselor Trainee Sex and Disability Training Project	Director Sex and Disability Unit
_____	_____
Coordinator Sex and Disability Training Project	Training Supervisor Sex and Disability Training Project

Date_____

SEX AND DISABILITY TRAINING PROJECT

GUIDELINES FOR LARGE AND SMALL GROUP EXPERIENCE

Group Leaders: David G. Bullard, Ph.D.
Susan E. Knight, B.S.
Mary M. Rodocker, R.N., M.S.

Participation: Participation by group members will be voluntary.

Purpose: Purpdses of large and small groups are to provide the opportunity for members to:
1) share their personal reactions to all aspects of the training program, to other trainees and to staff;
2) receive feedback from other trainees and staff relevant to the goals of the training program.

Techniques Used: Group activity will include personal sharing, role-playing, relaxation exercises, and desensitization exercises to help members become more comfortable with explicit sexual discussion.

Experience of Group Leaders: Information as to the relevant education, training, and experience of the group leaders will be provided upon request.

Responsibility for Participation: Each group member will be responsible for actively participating in group activities to the extent that he/she wishes.

Responsibility for Group: Group leaders, while encouraging group autonomy and responsibility, will retain ultimate responsibility for group activities. Small group leaders will meet weekly for consultation with Dr. Bullard.

Confidentiality: Group discussion will be held confidential by members of each group unless otherwise agreed by the group as a whole. Group leaders reserve the right to discuss group interaction at weekly consultation meetings attended by Dr. Bullard, Ms. Knight, and Ms. Rodocker.

Duration: The above groups will function according to the time schedule of the training program, from January 31, 1978 to January 24, 1979.

MEMORANDUM OF UNDERSTANDING

BETWEEN

SEX AND DISABILITY TRAINING PROJECT AND
HUMAN SEXUALITY PROGRAM
DEPARTMENT OF PSYCHIATRY
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

This cooperative relationship between the Sex and Disability Training Project (hereinafter called the "Project") and

(hereinafter called the "Agency") is agreed to for purposes of education and training, from

A. To fulfill its responsibility and obligations, the Agency agrees:

1. to provide a field placement setting within which _____, a Trainee of the Project, may obtain supervised experience in socio-sexual education and counseling with physically disabled and nondisabled persons. This activity may include but is not limited to conducting programs for staff and clients/patients/residents in socio-sexual education and counseling for individuals, couples, or groups.

2. that _____ will function as Agency Supervisor of the Trainee by meeting with and supervising his/her activities according to the following schedule:

3. that the Agency Supervisor will evaluate the Trainee's functioning by completing evaluation materials provided by the Project at the completion of the Trainee's period of field placement.

B. To fulfill its responsibility and obligations, the Project agrees:

1. that _____ will function as Project Supervisor of the Trainee by meeting with and supervising his/her activities for at least one hour every week during the Trainee's period of field placement.

2. that the Project Coordinator and the Project Supervisor will meet weekly to discuss the Trainee's activities.

3. that the Trainee is regarded as having an employee-type relationship with the University of California, San Francisco, and is therefore covered for malpractice, workman's compensation, and other liability while engaged in training activities at the field placement, as would be any other employee of the University.

C. To fulfill his/her responsibility and obligations, the Trainee agrees:

1. to conduct only those educational and counseling activities approved by the Agency Supervisor and by the Project Supervisor.

2. to commit himself/herself to the following schedule:

3. to complete patient and/or other records as requested by the Agency Supervisor.

4. to provide the Agency Supervisor with a summary report of his/her activities and experiences as a Trainee at the field placement, including a needs assessment of the agency in terms of socio-sexual education and counseling and recommendations as to how these needs can best be addressed.

D. Mutual Terms:

1. For purposes of supervision and evaluation, the Trainee, Agency Supervisor, and Project Supervisor agree to meet according to the following schedule:

2. This Memorandum of Understanding may be terminated by either the Agency, the Project, or by the Trainee at any time., with the reasons set forth in writing and submitted to David Bullard, Ph.D.

E. Special Considerations:

Trainee Sex and Disability Training Project	Agency Supervisor
Supervisor Sex and Disability Training Project	Coordinator Sex and Disability Training Project

Human Sexuality Program
University of California, San Francisco

SEX AND DISABILITY TRAINING PROJECT

FINAL EVALUATION
January 1978 - January 1979

Sex M____ F____ Please evaluate the following components of the training by circling or filling in your responses.

X _ _ - _ X - X _ _ _
S.S.# code

	In reference to my own need I found this: Not valuable 1 2 3 4 5 6 Very valuable	I found the adequacy of the presentation: Totally inadequate 1 2 3 4 5 6 Very adequate
"Health Aspects" Course	1 2 3 4 5 6	1 2 3 4 5 6
"Intro. to Sex Counseling" Course	1 2 3 4 5 6	1 2 3 4 5 6
Didactics (overall rating)	1 2 3 4 5 6	1 2 3 4 5 6
Supervision	1 2 3 4 5 6	1 2 3 4 5 6
Large-Group Interaction	1 2 3 4 5 6	
Small-Group Interaction	1 2 3 4 5 6	
Sex and Disability Films	1 2 3 4 5 6	
Research Paper	1 2 3 4 5 6	
Personal Journal	1 2 3 4 5 6	
Panel Presentations & Talks Made	1 2 3 4 5 6	
Client Counseling	1 2 3 4 5 6	
Trainees' Interaction	1 2 3 4 5 6	
Interaction with David Bullard	1 2 3 4 5 6	
Interaction with Susan Knight	1 2 3 4 5 6	
Interaction with Mary Rodocker	1 2 3 4 5 6	
Robert Geiger	1 2 3 4 5 6	

		Ineffective					Very Effective
Overall Course Content		1	2	3	4	5	6
Sexuality:	Effectiveness of presentation	1	2	3	4	5	6
	Time allotted for subject	Too little			Correct		Too much
	Comments:						
Disability:	Effectiveness of presentation	1	2	3	4	5	6
	Time allotted for subject	Too little			Correct		Too much
	Comments:						
Counseling:	Effectiveness of presentation	1	2	3	4	5	6
	Time allotted for subject	Too little			Correct		Too much
	Comments:						

READING ASSIGNMENTS

	Completed reading?		In reference to my own need I found this book: Not valuable ... Very valuable					
	yes	no	1	2	3	4	5	6
Survey of Med. for Rehab. Counselor	____	____						
Annon, Behavioral Treatment of Sex Problems	____	____	1	2	3	4	5	6
Bach and Wyden, Intimate Enemy	____	____	1	2	3	4	5	6
Barbach, For Yourself	____	____	1	2	3	4	5	6
Belliveau and Richter, Understanding Human Sexual Inadequacy	____	____	1	2	3	4	5	6
Brecher and Brecher, An Analysis of Human Sexual Response	____	____	1	2	3	4	5	6
Fensterheim and Baer, Don't Say Yes When You Want to Say No	____	____	1	2	3	4	5	6
Gagnon, Human Sexualities	____	____	1	2	3	4	5	6
Mooney et al, Sexual Options	____	____	1	2	3	4	5	6
Others you found helpful:								
_____	____	____	1	2	3	4	5	6

Briefly describe what you expected to obtain from the training:

Did the training meet your expectations? Yes_____ No_____ Partially_____

What did you not receive that you wanted?

What aspects of the training would you like emphasized for the next group?

How do you feel the training has affected you personally?

Very Negatively					Very Positively
1	2	3	4	5	6

In what specific ways has the training affected you personally?

How do you feel the training has affected you professionally?

Very Negatively					Very Positively
1	2	3	4	5	6

In what specific ways has the training affected you professionally?

We would appreciate any additional comments or suggestions regarding the training:

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September, 1978

Sex and Disability Training Project
Letter of Evaluation

June, 1977 - June, 1978

The Sex and Disability Training Project was funded in July, 1976 by the National Institute of Mental Health to develop a year-long, half-time training program dealing with issues of sexuality and physical disability. Persons selected for this training have varied backgrounds, including those with, and those without, previous training in counseling. All participants are physically disabled themselves and/or have worked or had significant personal relationships with disabled persons. was one of eleven counselor trainees during the second year of the project, and completed 1,000 hours of supervised instruction from June, 1977 to June, 1978.

Primary training staff included a clinical psychologist; a marriage, family and child counselor; and a social worker. A physician and a research psychologist provided ongoing consultation in addition to that provided by other specialists in the areas of counseling, disability and sexuality.

The training included didactic, research, field placement, group process, education and counseling activities, and assigned readings. Additionally, each trainee attended two University of California Medical School courses: Health Aspects of Human Sexuality (Psychiatry 160.14), and Introduction to Sex Counseling Principles (Psychiatry 160.15).

The following final evaluation is based upon data obtained from project and field placement supervisors, self-ratings and ratings by other trainees and clients, and critiques of workshop presentations and of research and field placement reports.

Participation

attendance was excellent despite a long weekly commute from the area. He frequently stimulated group discussion by asking pertinent questions of guest speakers and consistently contributed to the group process by sharing his observations and feelings.

Individual Research

completed a paper outlining a sociosexual education presentation format. His design is based on his own method of presenting with useful suggestions as to how

a person can vary the format according to personal style and audience needs. This outline could be utilized by individuals who are interested in organizing sex and disability workshops.

Field Placement

During the year of training chose to get experience at two rather than one field placements; one was at the the other was At , and another trainee conducted a group for disabled students interested in basic information about sexuality and ways to become more comfortable with themselves in social situations. At the with another trainee developed and conducted two separate groups. In each group he was creative and innovative in working with populations about which little in regard to socio-sexual concerns had been written. One group consisted of persons with strokes; the other was comprised of persons with varied disabilities and included those who were developmentally disabled. At the was able to establish a new program and his efforts were seen as very successful by the clients, staff, and the director. In particular, he was rated by his field placement supervisors as being very comfortable and knowledgeable in discussing sexuality and disability issues with clients and staff. He was rated as somewhat to fairly experienced as a counselor, and was given high ratings for his empathy and ability to communicate respect to his clients. These supervisors were extremely satisfied with the results of counseling and educational activities with clients and with his inservice presentations to staff.

Trainee Group

made good use of the group for enhancing his personal growth, especially in practicing assertiveness skills. He served as a good role model of a person who is aware of his feelings and able to verbalize them to others in an appropriate manner. When spoke, other group members listened attentively and seemed to respect and trust his perceptions of group process.

Education/Counseling

During the year made over 20 presentations to community agencies and professional groups regarding disability and sexuality issues. He made excellent use of personal sharing to help a wide variety of audiences recognize prevalent myths and biases about disabled persons. As a speaker, he makes good use of humor and is able to clearly articulate his thoughts. has the unique ability to talk about his anger with the rehabilitation process in a non-threatening manner so that professionals can hear and respond to it constructively, rather than defensively. In addition to the presentations, functioned as a small group facilitator in the Family Life Education Training for Teachers of Physically Disabled Students sponsored by University of California, San Francisco. He has been selected as a panelist and group leader for that same workshop to be held in 1, 1979. On the basis of 's role-playing and group interaction with other trainees and staff—as well as his experience with clients in the field placement setting and at the Sex and Disability Clinic, University of California, San Francisco we can evaluate his skills highly in the following areas:

1) ability to give validation of client's feelings and experience,

2) reflection of accurate empathy,

3) ability to give clear and relevant information and specific suggestions for desired client change, and

4) assistance in problem-solving while communicating respect for the client's own abilities.

In regard to client contact, we feel that can function skillfully and independently in both one-to-one and group situations with supervision. This is the highest level of recommendation given to persons completing the Sex and Disability Training Project.

Summary

As an educator and counselor, we feel that is a "natural". He has the ability to listen, to empathize, and to intelligently respond to others' concerns. He is generous in sharing of himself when that seems useful and appropriate. did much to enrich the experience of the training group as a whole.

David G. Bullard

David G. Bullard, Ph.D.
Coordinator
Sex and Disability Training Project

Susan E. Knight

Susan E. Knight
Director
Sex and Disability Unit

Mary M Rodocker

Mary M. Rodocker, R.N., M.S.
Training Supervisor
Sex and Disability Training Project

Robert C Gieger

Robert C. Gieger, M.D.
Medical Director
Sex and Disability Unit

tc

This certifies that

has completed

One Thousand Hours of Supervised Training in the

Training Project in Sex and Disability

Human Sexuality Program
Department of Psychiatry
University of California, San Francisco

Chairman, Department of Psychiatry

Director, Human Sexuality Program

Medical Director, Sex and Disability Unit

Director, Sex and Disability Unit

Coordinator, Sex and Disability Training Project

Training Supervisor, Sex and Disability Training Project

Staff and Consultant Resources

The following staff and consultants were involved with this project:

1. Principal Investigator and Director of Research and Evaluation, Human Sexuality Program

   10% of time; not supported by this grant.

   Douglas H. Wallace, Ph.D., Psychologist III and Assistant Clinical Professor of Medical Psychology (Psychiatry). He is a research psychologist whose interests and experience include studying the outcome of sex therapy and psychotherapy. Dr. Wallace served as a research consultant to the Project Coordinator and was responsible for statistical analyses of evaluation data.

2. Co-Principle Investigator and Project Coordinator

   100% time; supported by this grant.

   David G. Bullard, Ph.D., Psychologist II and Assistant Clinical Professor of Medical Psychology (Psychiatry). He is a clinical psychologist with a background in sex therapy, behavior therapy, and paraprofessional training. Dr. Bullard was responsible for didactic and group process instruction, curriculum development and course evaluation, staff supervison and overall project supervision.

3. Trainee Supervisor and Project Administrator

   90% time; supported by this grant.

   Susan E. Knight, M.S.W., Principal Administrative Analyst I and Director, Sex and Disability Unit, Human Sexuality Program. She is a social worker with seven years of experience in sex and disability education, counseling, and research. Ms. Knight was was responsible for administration of the project including coordination of field placements and development of employment opportunities for project graduates. She was also involved in instruction, supervision of trainees and trainee evaluation.

4. Trainee Supervisor and Clinic Director

   80% time; supported by this grant

   Mary M. Rodocker, R.N., M.S., Clinical Social Worker III and Director, Sex and Disability Clinic. She is a public health nurse with over five years of experience in sex therapy and education. Ms. Rodocker was responsible for the overall administration of the Sex and Disability Clinic, for instruction, supervision of trainees, trainee evaluation, curriculum development and evaluation.

5. Medical Director

   5% time; not supported by this grant.

   Robert C. Geiger, M.D., Assistant Clinical Professor in Orthopedic Surgery and Ambulatory and Community Medicine. He is an orthopedist with extensive experience investigating the impact of spinal cord injury and other medical conditions on sexuality. Dr. Geiger was responsible for instruction involving medical aspects of sexuality.

6. Director, Human Sexuality Program

10% time; not supported by this grant.

On June 1, 1978, Evalyn S. Gendel, M.D. was appointed Director of the Human Sexuality Program and Clinical Professor, Department of Psychiatry, University of California, San Francisco. She has had an extensive background in providing sexuality training to health professionals in relation to disabled and nondisabled children and adults. Dr. Gendel has responsibility for overall administration of the Human Sexuality Program.

7. Consultants

A core consultant to this project was Carla E. Thornton, R.N., M.S., Project Coordinator of a three year grant funded by the Bureau of Education for the Handicapped, Office of Education, HEW: Family Life Education Training for Teachers of Students with Physical Disabilities. Although not funded by the Sex and Disability Training Project, Ms. Thornton presented much information concerning the sociosexual development of disabled children. Also, project trainees were able to make presentations at workshops for teachers under the Family Life Education Grant.

A total of 50 different consultants were utilized over the three years of this project. Their names and topic areas are presented in Appendix C. Approximately 30% of these consultants were themselves disabled and hence were excellent role models for trainees.

SEX AND DISABILITY TRAINING PROJECT

7/01/76 TO 6/30/79

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